REPORT 1
ATASCADERO STATE HOSPITAL BASELINE EVALAUATION

November 13-17, 2006

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, M.D.) and three expert consultants (Vicki Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; and Elizabeth Chura, M.S.R.N.) visited Atascadero State Hospital (ASH) from November 13 to 17, 2006 to evaluate the facility's compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed baseline assessment of the status of compliance with all action steps of the EP.

The baseline assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

B. Methodology

The evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

C. Findings

This section addresses the following specific areas and processes that are not covered in the body of the compliance report.

1. Key Indicator Data

   The key indicator data are graphed and presented in the Appendix. At this stage, the following observations are made:

   a) The key indicator data provide a global assessment of the clinical and process outcomes at the facility and should not be seen as just another requirement of the EP. In their totality, the key indicator data provide an index of the facility's performance.
   b) At present, the key indicators lack completeness, consistency and reliability. As a result, the data cannot provide the basis for an accurate global assessment. Consequently, it cannot be used to improve the functional status of the individuals and/or drive changes in processes at the system level. The following are examples:
      i. The reliability of the data is an issue that must be addressed by the facility (e.g. serious incidents and seclusion and restraints data).
      ii. The data collection systems and the definitions of key indicators have been standardized statewide. However, ASH has yet to implement them consistently.
      iii. There is a need to accelerate efforts to automate data collection systems to improve consistency and timeliness in the gathering, aggregation and presentation of data across all facilities.
      iv. Important data are missing and available data are incomplete. Examples of missing information include data related to individuals' non-adherence to their WRPs, body weight changes and the use of PRN and Stat medications. Examples of incomplete data include medication variances.
      v. The data gathering system is fragmented and needs to be consolidated under Standards Compliance, with more effective leadership.

2. Monitoring and mentoring

   The facility has developed and implemented a variety of processes that utilize a number of monitoring tools to assess its compliance with the EP. However, it was very clear to the monitoring team that there were serious flaws inherent in the process used for self-monitoring. The following observations are relevant to this effort.

   a) Many of the facility's monitoring tools are well aligned with the requirements of the EP. Examples include the tools related to WRP Observations, WRP Chart Audits and the tools to assess psychiatric reassessments and inter-unit transfer assessments.

b) A significant number of the tools do not address the key requirements of the EP (e.g. Nursing, Social; Work and Rehabilitation Assessment tools).
c) Not all the tools are accompanied by instructions and operational definitions that can standardize the use within and across the facilities.
c) In many situations, the monitoring tools were not used accurately and the monitoring data had questionable validity and reliability.
d) The ratings were mixed. Some ratings were very well done and closely matched those of the Court Monitor's Experts (e.g. general medicine, Mall services and many indicators of psychiatric assessments). However, other ratings significantly differed from findings of the Court Monitor's Experts.
e) In many cases, the sample size monitored was far too small to be meaningful and the method of selection unstated. The sample size must be representative of the total population or subpopulations that are being assessed.
f) The facility provided irrelevant material as monitoring data, suggesting that the monitoring function is not well understood and lacks leadership.
g) Staff presenting the data to the Court Monitor's Team was often not well-informed about their own monitoring tools and/or data. Sometimes the staff presenting the data to the monitor challenged adequacy of assessments and monitoring tools developed by their own statewide committees and approved by this facility.
h) In some cases, critical data could not be located or had not been collected.
i) In some cases, the data analyses were substandard and the interpretation of the data was inadequate.
j) There was minimal indication that the data were used to enhance clinical practice.
k) There is no reliability data on internal monitoring. Approximately 20% of the data collected should be assessed for reliability.
l) Monitoring is not always undertaken by staff that is trained to competency in the process of monitoring. The frequent change in the core of monitors is a system's deficit that must be corrected.
m) All monitoring tools must be standardized for use statewide.
n) Given the amount of monitoring that is required, the tools and data collection must be automated.

The essence of collecting monitoring data is that it will be closely followed by feedback and mentoring. This was severely lacking in most areas. The monitors must be well versed in their respective areas with regards to the requirements of the EP and should also serve as the mentors to the staff and clinicians. The monitoring and mentoring functions cannot be divorced from each other. The chiefs of all clinical disciplines should have the administrative responsibility for monitoring and mentoring in their respective areas. Discipline seniors should be trained to not only monitor, but also mentor clinicians in their areas. In addition, there should be monthly reviews of the monitoring data at the facility level by all discipline chiefs and the senior executives so that the data can be used to enhance service delivery within the hospital. Further, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health

services provided throughout the DMH system. The EP was developed to change the DMH mental health system and not to change one hospital at a time.

3. Self-Evaluation

Using the above mentioned monitoring system, the facility has conducted a self-evaluation of its processes and status of compliance relevant to the EP. Although there are issues with the overall reliability of the data, the self-assessment process had the potential of being useful in evaluating the current status of compliance. This process is an essential tool to ensure proper attention by facility staff and leadership to the expectations of the EP as well preparing the facilities for eventual self-monitoring independent of external oversight. The following observations are important at this stage:

a) The above-mentioned monitoring deficiencies must be corrected to ensure that that the process is meaningful and has integrity.
b) In the process of verifying the validity and reliability of the data, the court monitor and expert consultants require that the facilities readily demonstrate methods of data collection, where the data is documented and information about timeliness, completeness and quality of the documentation.
c) To ensure the proper utilization of the current monitoring tools in the process of self-evaluation, the tools must address quality of services and not be limited to timeliness and presence or absence of various components. It is expected that quality indicators change slowly overtime, but the process must be oriented to these indicators from the beginning.
d) Other issues were noted in specific areas. For example, nursing staff is wedded to a very specific medical model that is fairly irrelevant to psychiatric nursing in a facility (and system) that has moved to recovery and psychiatric rehabilitation as the basis for their services. Thus, their assessments and monitoring are not closely aligned with the WRP system used by the rest of the disciplines.
e) Even though the Court Monitor provided details of the planned evaluation for each section of the EP for assessing the quality of clinical services, it was not fully used as the basis for the self-evaluation.
f) Staff presenting the self-evaluation reported that there was a lack of accountability in the self-evaluation process. The facility produced more than 600 pages that showed little understanding of the evaluation required by the EP and suggests a lack of administrative and clinical leadership in this process.
g) The matrix model used by the facility highlights the administrative leadership of the Program Directors, but the EP requires the clinical chiefs to be held accountable for the clinical outcomes. Thus, the clinical chiefs appear to have the responsibility but not the authority to implement and produce the outcomes expected by the EP.

4. Implementation of the EP

a) Structure of current and planned implementation:
   i. The State and its consultants have instituted a person-centered wellness and recovery oriented model of service delivery. This model embodies all the key requirements of the EP. It provides the basis for services that can meet the full needs of individuals, including not only reduction of symptoms of the illness but also provision of skills and supports to assist individuals in overcoming the impairments that accompany the illness and interventions to improve the quality of life of the individuals.
   ii. The Wellness and Recovery Planning (WRP) model is a state-of-the-art system that utilizes the potential of the recovery model for all individuals served in the state inpatient system, including all individuals with forensic issues.
   iii. The Positive Behavior Support (PBS) and By CHOICE programs are by design state-of-the-art.
   iv. The Psychosocial Rehabilitation Mall (PSR) mall is state-of-the-art in terms of its potential for delivering recovery-focused services.
   v. The DMH-approved monitoring system has the potential for demonstrating the effectiveness of the recovery-oriented psychiatric rehabilitation of the individuals served in the DMH forensic hospitals.

b) Function of current and planned implementation:
   i. Although there is an excellent manual of WRP, the implementation of the principles and practice requirements outlined in this manual is, in general, inadequate. The content of the WRPs is deficient in almost all the key components, including case formulation, foci of hospitalization, objectives and interventions.
   ii. Many staff members are not familiar with the actual requirements of the EP and therefore have little knowledge of the key changes that they need to make.
   iii. Although some professionals and direct care professionals have embraced the new model, some key disciplines have not yet learned the model or accepted its potential to achieve the desired outcomes.
   iv. Staff is not fully conversant with the recovery model, concepts of psychiatric rehabilitation, and the PBS and By CHOICE systems. Most of the interdisciplinary providers are not yet trained to competency regarding the principles and practice of the new model.
   v. Functional outcomes of the current structural changes are yet to be identified and utilized to guide further implementation.
   vi. In general, staff appears to utilize the format of the new system to transfer the same content of the old system.
   vii. This hospital has yet to implement a system to ensure linkage between interventions provided at the PSR Mall and objectives outlined in the WRP. At present, there is a disconnection between the Mall activities and the WRP and between the Mall Manual and actual group interventions.

viii. The EP requirements are being phased in as staffing and other considerations allow. This piecemeal approach does not facilitate the implementation of the core requirement of the EP regarding the use of the WRP and PSR Mall service delivery system. Not introducing both the WRP and PSR Mall systems within a short period of time across the whole facility has resulted in differential treatment of the individuals served at ASH. Further, our findings suggest that there is a gap between the training of staff and actual implementation of services systems because training appears to precede implementation by many months.

5. Staffing

The ASH staffing table below shows the staffing pattern at the hospital as of September 30, 2006. These data were provided by the California DMH. The table shows that there is a major shortage of staff in several key areas: psychiatric technicians, registered nurses, senior psychiatric technicians, staff psychiatrists, staff psychologists, pharmacists and teacher-adult educators/vocational instructors. Also, many clinicians hold administrative positions and thus there are even fewer staff available to work directly with the individuals. The Executive Director of ASH presented data to the Court Monitor's team regarding the staffing configuration as of November 13, 2006. These data showed even more severe shortages in most key specialties.

The facility has attempted many ways of recruiting and retaining staff, but has not been successful in filling their vacancies. Given the dire shortage of staff at ASH and most of the other hospitals, DMH must seriously consider contracting with a staffing and consulting company with national experience in recruiting professional clinical staff. The current staffing shortage, especially in psychiatry, nursing, psychology and pharmacy is detrimental to the clinical care of individuals served in DMH forensic hospitals. The recent pay increase for these specialties at the Department of Corrections is likely to worsen the staffing situation at the DMH hospitals before the State may be able to correct this problem.

In addition, the hospital should have a rational plan for redeploying its clinical staff. For example, two well-qualified psychologists are employed as administrators in the EP implementation system when the deputy Treatment Enhancement Coordinator can well handle the job with full-time secretarial assistance. There are multiple independent committees, groups and projects (e.g. Standards Compliance, Evaluation Outcomes Services, Central Nursing Services and Clinical Safety Project) that collect data on incidents, violence, restraints and other key variables. Many of these group and project members are clinicians who can be better utilized in WRP teams where clinicians are in short supply. Data collection should be centralized under strong leadership in Standards Compliance. The facility has a history of staffing shortages and there is an urgent need for a dramatic change in its current staffing patterns.

Identified Clinical Positions	Budgeted Positions (05/06 FY)	Filled	Vacancies
Assistant Coordinator, Nursing Services	1.00	0.00	1.00
Assistant Director, Dietetics	3.00	3.00	0.00
Audiologist I	0.00	0.00	0.00
Chief Dentist	1.00	1.00	0.00
Chief Physician and Surgeon	1.00	1.00	0.00
Chief, Central Program Services	1.00	1.00	0.00
Clinical Dietician/Pre-Reg. Clin. Dietician	9.00	8.20	0.80
Clinical Laboratory Technologist	4.50	3.50	1.00
Coordinator, Nursing Services	1.00	1.00	1.00
Coordinator, Volunteer Services	1.00	1.00	0.00
Dental Assistant	3.00	3.00	0.00
Dentist	1.00	1.00	0.00
Dietetic Technician	2.50	2.50	0.00
E.E.G. Technician	1.00	1.00	0.00
Hospital Worker	0.00	0.00	0.00
Health Record Technician	5.00	2.00	3.00
Health Services Specialist	26.00	26.00	0.00
Institution Artist Facilitator	1.00	1.00	0.00
Licensed Vocational Nurse	2.00	2.00	0.00
Medical technical Assistant	0.00	0.00	0.00
Nurse Instructor	11.00	10.00	1.00
Nurse Practitioner	17.00	13.50	3.50
Nursing Coordinator	7.00	1.00	6.00
Office Technician	41.10	11.00	30.10
Pathologist	0.00	0.00	0.00
Pharmacist I	14.00	10.00	4.00
Pharmacist II	2.00	1.00	1.00
Pharmacy Services Manager	1.00	1.00	0.00
Pharmacy Technician	15.00	15.00	0.00

Physician & Surgeon	14.00	14.00	0.00
Podiatrist	0.00	0.00	0.00
Pre-Licensed Pharmacist	0.00	0.00	0.00
Pre-licensed Psychiatric Technician	26.00	26.00	0.00
Program Assistant	8.00	7.00	1.00
Program consultant (RT, PSW, Psych)	2.00	2.00	0.00
Program Director	7.00	7.00	0.00
Psychiatric Social Worker	65.00	56.00	9.00
Psychiatric Nursing Education Director	1.00	1.00	0.00
Psychiatric Technician	640.70	420.00	220.70
Psychiatric Technical Trainee	76.00	760	0.00
Psychiatric Technician Assistant	17.00	17.00	0.00
Psychiatric Technician Instructor	2.00	2.00	0.00
Psychologist-HF, (Safety)	55.50	47.10	8.40
Public Health Nurse II/I	3.00	3.00	0.00
Radiologic Technologist	0.00	0.00	0.00
Registered Nurse	314.00	170.80	144.00
Reg Nurse Pre-Registered	0.00	0.00	0.00
Rehabilitation Therapist	61.00	47.30	13.70
Special Investigator	0.00	0.00	0.00
Speech Pathologist I	0.00	0.00	0.00
Sr. Psychiatrist	4.00	4.00	0.00
Sr. Psychologist	7.80	5.00	2.80
Sr Psych Tech (Safety)	95.00	74.00	21.00
Sr Radiologic Technologist (Specialist)	1.00	1.00	0.00
Sr. Voc. Rehab Counselor/Voc. Rehab. Counselor	3.00	2.00	1.00
Staff Psychiatrist	47.50	36.00	11.50
Supervising Registered Nurse	2.00	2.00	0.00
Teacher-Adult Educ. /Vocational Instructor	33.00	9.00	24.00
Teaching Assistant	7.00	4.00	3.00
Unit Supervisor	33.00	33.00	1.00
Vocational Services Instructor	4.00	3.00	1.00

D. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes.
3. Interviews with individuals, staff, facility and State administrative and clinical leaders.
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future.
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that is inconsistent with these patterns and trends.
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for This Evaluation.

E. Next Steps

1. The Court Monitor's team is scheduled to tour PSH from December 4 to 8, 2006.
2. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

Section	Enhancement Tasks	
A	**Definitions**	
1	**Effective Date**	
	The Effective Date will be considered the first day of the month following the date of execution of the agreement by all parties. Unless otherwise specified, implementation of each provision of this Plan shall begin no later than 12 months after the Effective Date.	
2	**Consistent with Generally Accepted Professional Standards of Care**	
	A decision by a qualified professional that is substantially aligned with contemporary, accepted professional judgment, practice, or standards as to demonstrate that the person responsible based the decision on such accepted professional judgment.	
B	**Introduction**	
	Each State hospital shall use a Recovery philosophy of care and a Psychiatric Rehabilitation model of service delivery. Therapeutic and rehabilitative services provided by each State hospital shall be based on evidence-based practices and practice-based evidence, shall be age-appropriate, and shall be designed to: strengthen and support individuals' recovery, rehabilitation, and habilitation; enable individuals to grow and develop in ways benefiting their mental health, health and well being; and ensure individuals' reasonable safety, security, and freedom from undue bodily restraint. Relationships between each State hospital staff and the individuals whom they serve shall be positive, therapeutic and respectful.	
	Each individual served by each State hospital shall be encouraged to participate in identifying his or her needs and goals, and in selecting appropriate treatment options. Therapeutic and rehabilitation services shall be designed to	

	address each individual's needs and to assist individuals in meeting their specific recovery and wellness goals, consistent with generally accepted professional standards of care. Each State hospital shall ensure clinical and administrative oversight, education, and support of its staff in planning and providing care and treatment consistent with these standards.	

C	Integrated Therapeutic and Rehabilitation Services Planning	
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress**: 1. ASH is transitioning from a traditional medical, psychiatric, and forensic model of care to a person-centered Wellness and Recovery system. 2. ASH has a Wellness and Recovery Plan (WRP) manual that codifies state-of-the-art elements in recovery-oriented services for individuals with serious mental illnesses. 3. ASH provides services within an interdisciplinary team model. 4. ASH has a substance abuse program that is guided by the generally accepted trans-theoretical model of care. 5. Many of the providers at ASH are dedicated and caring professionals who are making a sincere effort to provide services within the new system. 6. ASH has implemented the new template for the Wellness Recovery Plan (WRP) in many of its programs and is currently in the process of converting the remaining programs to the new model. 7. ASH has initiated the implementation of a new model of providing services to individuals through the Psychosocial Rehabilitation Mall. This model represents current professionally accepted standards in psychosocial rehabilitation of individuals with serious mental illnesses in hospital settings. 8. ASH has developed and implemented a variety of monitoring instruments, including both process observations and chart audits, to assess its compliance with the EP. 9. ASH has completed a self-assessment process based on current monitoring instruments. The process has heightened staff's awareness of the EP and its expectations. 10. ASH made some major efforts to train staff to use the new monitoring instruments, particularly in Section C.2 and this effort is to be commended.

1	**Interdisciplinary Teams**	
	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** Interviewed David Fennell, M.D. Medical Director. Interviewed Mark Becker, Ph.D. Chief of Wellness and Recovery Support. Interviewed Diane Imrem, Psy.D. Treatment Enhancement Coordinator. Observed WRP team meetings to develop master WRPs for two individuals (LP and TE). Observed WRP team meetings for quarterly WRP reviews of two individuals (RP and EOR). Reviewed the DMH WRP Manual (Draft July 7, 2006). Reviewed AD # 414-Wellness and Recovery Planning (WRP). Reviewed AD # 507 Interdisciplinary and/or Wellness and Recovery Teams. Reviewed DMH WRP Observation Monitoring Form. Reviewed WRP Observation Monitoring Form Instructions. Reviewed Observation Monitoring Summary Data (September 2006). Reviewed DMH Case Formulation Monitoring Form. Reviewed DMH Case Formulation Monitoring Form Instructions. Reviewed Case Formulation Monitoring Summary Data (September 2006). Reviewed Medical Staff Rules and Regulations. Reviewed Department of Psychiatry Manual. Reviewed WRP Conference Task Tracking Sheet. Reviewed WRP ASH Phase I Training Post Test. Reviewed WRP Phase II Training status database. Reviewed records regarding attendance by WRP teams in the WRP Phases II and III training sessions. Reviewed a list of Medication Management Groups, with individuals, provider and location

a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Findings:** ASH utilizes the draft DMH WRP manual. The manual (section 3. Assessments, 3.2 Integrated Assessments, 3.4 Strengths, 3.5 stages and Readiness of Change) contains state-of-the-art principles and practice requirements in recovery-oriented services that meet the requirements in this section. ASH has an AD (#414) regarding the new WRP model, which is derived from the DMH WRP manual. The AD includes an overview of the requirements regarding development of case formulation, goals and objectives and interventions as well as plan revisions. AD # 507 addresses some administrative aspects of the interdisciplinary team functions but is not aligned with the WRP model. ASH is in the process of converting from the old Computer Assisted Treatment Plan-Atascadero (CATPA) to the WRP system. By October 2006 four of the facility's seven Programs have completed the conversion process with the remaining three Programs scheduled to complete the conversion roll-out by January 2007. ASH has instituted a training program for its WRP members regarding the principles and practice of WRP. The program has three phases: introductory, practical applications and in-vivo training on units. The State consultant provides the training on an ongoing basis. ASH has developed a post-training test to assess competency of trainees. However, at present, there is no documentation that WRP core team members have been trained to competency. The facility used the DMH WRP Observation Monitoring Form to assess its compliance with this section. The monitoring indicators are aligned with requirements of the EP. In this process, 39 WRP Conferences were observed during September 2006. The reviews were conducted by a team of six clinicians led by Mark Becker, Ph.D.

		Eleven of the conferences were seven-day WRP meetings and 28 were quarterly meetings. Observers were trained and inter-rater reliability was established at 90%. The facility has data that demonstrate low compliance rate (3%) with the requirement that the WRP Conference functioned in an interdisciplinary fashion (as defined by the Observation Monitoring Form Instructions). The facility also reviewed 65 charts using the DMH Case formulation Monitoring Form. The data indicate 5% of the meetings were found to be "interdisciplinary" as defined by the DMH Case Formulation Monitoring Form instructions. ASH does not have a chart audit system at this time. The facility has identified the limited bed capacity on the admissions service as a barrier to proper implementation of the WRP model. The facility reports that individuals are transferred from the admission service to a long-term unit before their WRPs are sufficiently complete or adequate details are obtained to support the planning process. To address this issue, the facility increased the number of admission units by 50% (from two to three 2 to 3) and is currently developing plans to increase its capacity up to a total of eight units. This monitor's observations of WRP team meetings (see C.1.b. through C.1.f) and review of charts (see C.2) indicate that, in general, the process and content of Wellness Recovery Planning at ASH are deficient and that the principles and practice elements outlined in the DMH WRP manual are yet to be properly implemented. **Compliance:** Partial.

		Recommendations: 1. Finalize, approve and implement the DMH WRP manual. 2. Provide documentation that WRP team members have been trained to competency. 3. Continue and strengthen current training program. In addition, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRP teams. 4. Streamline and refine current WRP monitoring instruments to reflect the specific recommendations in each of sections C.1.b through C.1.g below. The monitoring instruments should contain operational criteria that address the specific requirements in each section. 5. Standardize the WRP monitoring instruments and sampling methods across State facilities. 6. Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1. and C.2. 7. Ensure that the AD regarding WRP is aligned with all the provisions in the DMH WRP Manual. 8. Ensure a stable core of process observers and chart auditors who have been trained to competency by the state consultants.
b	Be led by a clinical professional who is involved in the care of the individual.	**Findings:** At ASH, the Psychiatrists are designated as the team leaders and coverage is provided by Psychologists or Social Workers during the absence of the designated leaders. The facility has utilized the DMH WRP Monitoring Form to assess compliance with this item. The previously described process was used.

		The facility has data that indicate 82.1 % compliance with the requirement that had an identified core WRP team member facilitate the conference (psychiatrists, psychologists and social workers most frequently filled this role). Further analysis of data was performed to assess the functioning of the team leader during the meetings. The facility found that none of these facilitators (0%) across all disciplines led a conference that successfully met all the observation tool's criteria. The criteria were aligned with the EP's requirements in Section C.1.. The facility concluded that none of these WRPC facilitators had the knowledge, skill, cooperation, authority/responsibility, system support, and/or resources necessary to lead a conference that meets the requirements of the Recovery Model or the EP. The facility does not regularly monitor both attendance and participation by psychiatrists and the covering professionals. The team meetings that this monitor attended included participation by psychiatrists as team leaders in all cases. However, the team meetings demonstrate that the team leaders do not perform their primary function of ensuring a structure that allows members to: a) provide, combine and coordinate their efforts; b) address all relevant planning issues during the meeting time; and c) obtain meaningful input from the individuals. The teams spent most of the meeting times in conducting a series of disciplinary assessments rather than actual planning of services. The individuals' participation was mostly limited to answering questions during these assessments. In reviewing the DMH WRP manual, this monitor observed that the sequence of tasks identified in the manual regarding the team member responsibilities does not include the responsibility of the leader to ensure that members: a) communicate results of the assessments prior to the planning process; b) understand the

		parameters for meaningful participation by the individual in the WRP meeting; and b) update the present status section of the case formulation. The DMH WRP manual includes team responsibilities at 7-day, 14-day, monthly, quarterly and annual conferences. The responsibilities at the 14-day and monthly reviews do not include discussion of Positive Behavior Support (PBS), data regarding monitoring instruments (MOSES) and the individual's current medical status. **Compliance:** Partial. **Recommendations:** 1. Monitor both presence and proper participation by the team leaders in all WRP meetings. 2. Develop and implement a peer mentoring system to ensure competency in team leadership skills. 3. The Department of Psychiatry Manual should include specific requirements regarding WRP leadership. The requirements must be aligned with the WRP team responsibilities that are outlined in the DMH WRP manual. 4. The DMH WRP manual should address the leader's responsibility to ensure that members provide concise presentation of the results of their assessments prior to the discussion of objectives and interventions. 5. The DMH WRP manual should specify the leader's responsibility to ensure appropriate parameters for participation by the individual in their treatment, rehabilitation and enrichment activities. 6. The DMH WRP manual should address the leader's responsibility to ensure that the present status section of the case formulation is updated during the WRP team meetings and that other sections in the formulation are consequently

		updated as clinically indicated. 7. The DMH WRP manual should combine tables 5.1 and 5.2 regarding team responsibilities during WRP reviews to include the same expectations regarding discussion of PBS data, MOSES data and the individual's current medical condition.
c	Function in an interdisciplinary fashion.	**Findings:** The DMH WRP manual (section 5.2, WRP Team Responsibilities at 7-day, 14-day, quarterly, monthly and annual reviews) outlines the responsibilities of each team member. This outline contains the key requirements that enable an effective interdisciplinary process. As mentioned earlier, the facility reports a compliance rate of 3% with this requirement. A WRP team was considered to function in an interdisciplinary fashion, process-wise, if all of the following criteria were observed: 1. The core team members participated by presenting or updating discipline-specific and/or holistic assessment data. 2. The team reviewed and updated the WRPC assessment/data gathering Tracking Form. 3. Various team members presented their or non-team member clinician's assessments and consultations as identified as due by the Tracking form. 4. Team members discuss the individual's specific outcomes/progress (or lack there of) for the WRP review period. This monitor's findings under C.1.a are also applicable to this section. These findings corroborate the facility's low compliance rates. **Compliance:** Partial.

		Recommendations: Same as in C.1.a. and C.1.b.
d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Findings:** As mentioned above, the DMH WRP manual outlines the responsibilities of each team member in a manner that enables an effective interdisciplinary process. AD # 414 regarding WRP states that the psychiatrist as team leader has the final responsibility for the plan. The medical Staff Rules and Regulations and the Department of Psychiatry Manual do not address the specific requirements regarding the role of psychiatrists as team leaders. The team meetings attended by this monitor indicate a pattern of deficiency regarding the team leaders assuming the primary responsibility for the individual's therapeutic and rehabilitation services. Findings regarding the performance of team leaders in the provision of competent psychiatric and medical care are detailed in Sections D and F below. **Compliance:** Partial. **Recommendations:** 1. Same as in C.1.a, b and c. 2. Conduct surveys to assess the views of team members regarding the functions of their designated leaders. 3. The Department of Psychiatry Manual should include specific requirements regarding psychiatrists' role as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual.

e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Findings:** ASH utilized the WRP process observations described earlier to assess compliance with this item. The facility has data that indicate 0% compliance with the requirement that all of following criteria is met: 1. The core team members participated by presenting or updating discipline-specific and/or holistic assessment data. 2. The team members presented their own and as needed non-team member assessment and consultation results as identified as due by the Tracking form. 3. Team members discuss the individual's specific outcomes/progress (or lack there of) for the WRP review period. **Compliance:** Partial. **Recommendations:** 1. Same as in C.1.a. through C.1.d. 2. Same as in D.1.a. through D.1.e. 3. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 4. Ensure that the monitoring tools adequately address the quality of disciplinary assessments.
f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the	**Findings:** ASH has observation monitoring data based on the same process that indicate 3% compliance with this requirement

	next review.	Observations of the team meetings attended by this monitor indicate general deficiency in the key requirements of presenting results of the assessments and analyzing those results to assess implications for diagnosis, treatment and/or rehabilitation of individuals. **Compliance:** Partial. **Recommendations:** Same as in C.1.a through C.1.e.
g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Findings:** The DMH WRP manual (3. Assessment, 3.1 Admission Assessment, 3.2 Integrated Assessment, 3.3 Clinically Indicated Assessment, 3.6 Assessment Schedule, 4. WRP Schedule and 4.3 WRP Conferences) includes practice requirements regarding the key elements in this step. As mentioned earlier, the facility has yet to complete its transition to the WRP model. At this time, ASH requires that the WRP reviews are performed according to the schedules established in the DMH WRP manual. However, the facility has not implemented the requirements regarding the initial WRP (within 24 hours of admission) and the integrated psychiatric assessments (within seven days of admission). ASH monitors the responsibility for drafting of WRPs and for review and revision of the plans as per schedule. Although in all of the WRPCs observed someone was identified "to be responsible for the scheduling" of team meetings (not of assessments) and for typing the WRP, none of these WRP team

		members (0%) gave the individual an appointment card for the next WRPC or completed the WRPC Task Tracking Form (the form tracks the type, responsibility and timeframes regarding the assessments).. **Compliance:** Partial. **Recommendations:** Address the deficiency in the implementation of this requirement and ensure compliance.
h	Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.	**Findings:** The DMH WRP manual (2. Brief Definitions, 2.3 The WRP Team, 5. WRP Team Member Responsibilities) contains needed information regarding this requirement. The facility does not have database that includes information regarding the core membership of all teams in the facility. ASH has monitoring data that assess the attendance by core members in its WRP team conferences. Based on the 39 WRPCs observed by the facility, an overall compliance rate of 79% was reported. The percent of teams in which representatives of the core disciplines attended the meeting was as follows: Individual : 92% Psychiatrist: 87% Psychologist: 58% Social Worker: 79% Rehabilitation Therapist: 84% Registered Nurse: 97% Psychiatric Technician: 54%

		The facility's Medical Director indicates that the facility has a high turnover rate in the core membership due to difficulties in recruiting staff. **Compliance:** Partial. **Recommendations:** 1. Develop database that includes information regarding the core membership of all teams in the facility. 2. Address and correct the deficiencies regarding attendance by core members. 3. Regularly monitor the attendance by core members in the WRP team conferences.
i	Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.	**Findings:** ASH has data that indicate non-compliance with this requirement. The facility has three admission units. Each unit has only one complete WRP team...The average ratio of core members to individuals on these units is approximately 1:32. The other treatment units have ratios that vary from 1:27 to 1:51. The ratio of psychiatrist is even more variable as several psychiatrists are assigned to more than one unit. The ratios for psychiatrists vary from 1:27 up to 1: 120. The census per unit varies with the census management. When the facility is over census, then over bedding is done on the larger units, which further increases the ratio. **Compliance:** Partial **Recommendations:** 1. Ensure consistent compliance with this requirement. 2. Same as in recommendation #3 under C.1.h.

j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Findings:** The facility has data regarding attendance by different disciplines in the WRP training. This monitor reviewed the facility's raw data and found variance among the disciplines with a range of 56% (Psychiatry) to 88% (Psychology and Nursing). To address this finding, the Medical Staff is in process of modifying its Rules and Regulations to ensure that its peer review process includes specific performance goals related to WRP. The training records at ASH track post-test competencies regarding the didactic first phase of WRP training. The test does not reflect expectations regarding process requirements of WRP that are specified in the DMH WRP Manual. The facility has yet to develop mechanisms to ensure competencies in phases II and III of this training. This monitor's observations of team meetings reveals that most team leaders and members are not yet fully trained to meet this requirement. **Compliance:** Partial. **Recommendations:** 1. Same as in C. 1.a through C.1.f. 2. Revise the current WRP Phase I post-test to include the WRP process expectations. 3. Ensure the development and implementation of mechanisms to ensure that all WRP team members are competent in all phases of WRP training.

2	**Integrated Therapeutic and Rehabilitation Service Planning (WRP)**	
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** Observed WRP team meetings to develop master WRPs for two individuals (LP and TE). Observed WRP team meetings for quarterly WRP reviews of two individuals (RP and EOR). Observed Mall Groups. Reviewed charts of 72 individuals (DF, JR, EG, TR, ZS, EL, TS, MC, EN, TC, GM, JB, JD, CP, CD, CG-1, LP, TMC, AB, GH, MC. KL, BE, GP, MW, JJ, TE, LEM, PC, RP, QW, NC-1, SO, DA, DM, TG, RR, RA, CG-2, JO, JJF, ATM, SD, PJC, RA, MD, HTK, NC-2, AI, VBT, WT, KEL, JJC , JJM, TL, XF, AC, KR, FM, CJ, OR, AM, AW, AJ, RS, JM, CW, OP, CS, AF, AM and TH). Interviewed Matt Hennessy, Psy.D., Psychologist and Mall Director. Interviewed Dianne Imrem, Psy.D., Senior Psychologist and Treatment Enhancement Coordinator. Interviewed Howard Hallum, MA, Supervisor of Substance Abuse Services. Interviewed Sherry Hood, RN, unit 14, Program V. Interviewed Mr. Charlie Joslin, Program Director, and Acting Clinical Administrator. Interviewed Ms. Susan Cahill, staff service analyst. Interviewed Mr.John Rich, LCSW, BY CHOICE Coordinator. Reviewed Substance Abuse Central Program Services (CPS) Directive #601. Reviewed DMH WRP Manual (Draft July 7, 2006). Reviewed AD # 414 regarding Wellness and Recovery Plan (WRP). Reviewed DMH WRP Observation Monitoring Form. Reviewed DMH WRP Observation Monitoring Form Instructions. Reviewed ASH Observation Monitoring Data Summary (September 2006). Reviewed ASH WRP Chart Auditing Form. Reviewed WRP Chart Audit Data Summary (September 2006)

		Reviewed DMH Case Formulation Monitoring Form. Reviewed DMH Case Formulation Monitoring Form Instructions. Reviewed DMH Case Formulation Monitoring Data Summary (September 2006). Reviewed form regarding WRP Individual Participation Survey (September 2006). Reviewed Individual Participation Survey Summary Data (September 2006). Reviewed Substance Abuse Service Manual. Reviewed Central Program Services Directive #601 regarding Substance Abuse Treatment Program. Reviewed Substance Abuse Service intake Assessment Form. Reviewed Residential Programs' Substance Abuse Curriculum. Reviewed DMH Draft Policy regarding Screening for Substance Abuse. Reviewed Substance Abuse Monitoring Tool. Reviewed Substance Abuse Monitoring Summary Data (September 2006). Reviewed Patient Attendance Records (PAR). Reviewed BY CHOICE fidelity check. Reviewed PSR Mall Schedule. Reviewed PSR Mall Curricula and Manuals. Reviewed Psychosocial Active Treatment List. Reviewed Psychosocial Enrichment Activity List. Reviewed DMH Positive Behavior Support Integrity Checklist. Reviewed list of all individuals by program x unit x scheduled hours of Mall groups or individual therapy x actual hours attended.
a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Findings:** ASH has data to indicate that, as of September 2006, the facility had converted 769 treatment plans (approximately 61% of all plans) to the new WRP format. The facility used three mechanisms to monitor these WRPs in order to assess compliance with provisions of

		Section C.2. The following is an outline of these mechanisms: 1. WRP Conference Process Observation: The facility used the DMH WRP Observation Monitoring Form as previously described in C.1.a. 2. WRP Chart Audits: The facility developed a list of its WRPs and selected every fifth plan for chart audit to include at least one plan from each unit. This resulted in a sample of 154 WRPs (20% of the converted WRPs). The facility used ASH WRP Chart Auditing Form as the monitoring tool and trained 11 staff members on the use of this Tool. The tool includes indicators that are aligned with requirements of the EP. Inter-rater reliability was not established. The audits were completed by October 2, 2006. Auditors were instructed to review the individuals' most recent WRP. Of the 154 WRPs, only 107 audits (14% of the converted WRPs) were completed. The facility identified a variety of factors contributing to the relatively low completion rate. These include individuals being discharged, WRPs not being completed and/or available, and one auditor's results not being turned in. The results of the 107 WRP Chart Audits were entered into a database and reported throughout section C2. 3. WRP Case Formulation Audits: The facility used the newly developed DMH Case Formulation Monitoring Form. The form contains indicators that are derived from requirements of the EP. In this process, two quarterly WRPs from each unit (n=68) were randomly selected from the list of 154 WRPs that was developed for the WRP Chart Audit sample. The sample represents 9% of the converted WRPs. The facility trained 12 staff members on the use of the Case Formulation Monitoring Tool on September 27, 2006. Inter-rater reliability was not established. (However, 11 of the 12 auditors completed their audits in the same room with the trainer present to answer questions). Audits were completed

		by October 2, 2006. Auditors were instructed to review the individuals' most recent WRP. Of the 68 Case Formulation Audits, 65 were completed (8% of the converted WRPs). The results were entered into a database with the results for specific items were reported. The facility reports that 39 WRPs (approximately 50% of the sample) were in compliance with the WRP observation monitoring item (#6) stating that "individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to Mall groups and therapies appropriate to their WRP." In addition, the facility surveyed all individuals on two programs (n=364) to assess how they viewed their participation in the WRP. Approximately 65% of these individuals completed the survey. The following is a review of the relevant questions used in the survey and the percentage of individuals who responded in the affirmative: 1. Does your Wellness and Recovery Plan have your Life Goals stated in your own words? (68%); 2. Do you have the opportunity to provide input into or to choose the Mall groups, individual or group therapy, and enrichment activities that are assigned to you in your Wellness and Recovery Plan? (68%); 3. Do you know the objectives you are working on in your Wellness and Recovery Plan? (72%); and 4. Does your Wellness and Recovery team ask for your input in evaluating the progress you have made in meeting each objective in your Wellness and Recovery Plan? (61%). As mentioned in section C.1, this monitor's observations of the WRP team meetings indicate that, in general, the teams do not obtain meaningful input from the individuals in the process of review and revisions of the plans. The main deficiency is that the individual's

		input is obtained in the context of performing/completing disciplinary assessments rather than interdisciplinary planning of the services necessary to meet the individual's assessed needs. This monitor observed that several team members rely on the WRP meetings to conduct their assessments. The assessments must be completed prior to the WRP meetings. Delaying these assessments till meeting time impedes planning of services and also results in unacceptable delays in determining the current status of the individual regarding a variety of risk factors and in the institution of timely interventions to reduce the risk. In some cases, the individuals were given choices among PSR groups. However, the PSR groups were selected from standard group offerings and were not matched to the individual's needs. The match between what the individuals needed and the choices offered were tenuous. At times, objectives and discharge criteria were developed without input from individuals whose functional status permitted such input. In general, the WRP teams were not following the instructions in the DMH WRP Manual. **Compliance:** Partial. **Recommendations:** 1. Same as in C.1.a through C.1.f. 2. Ensure that self-assessment data address all requirements of the EP using both process observation and chart audit tools, as appropriate. 3. Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.

b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	**Compliance:** Partial.
b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Findings**: ASH has not implemented the A-WRP. The facility has chart audit data that indicate 0% compliance with this requirement. The facility identified an error in its chart audit data. It appears that some WRPs that should have been marked as "Not Applicable", were marked as "No", thus inflating the number of "No" responses and decreasing the overall percentage of compliance. However, chart reviews by this monitor (DF, JR, EG, TR, ZS, EL, TS, MC, EN, GM and TC) corroborated the facility's rate of 0% compliance. **Recommendations:** 1. Implement requirement regarding timeliness of the initial WRP. 2. Continue chart audits to assess compliance.
b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Findings**: The facility has chart audit data to assess compliance with this requirement. The facility selected 33 of the 107 charts for review The data indicate that 24% of the master WRPs were developed on or before the seventh work day after admission. The facility recognized the same data error that was reported in C.2.b.i. This monitor reviewed 16 charts and found evidence of inadequate compliance with this requirement. The review showed non-compliance in ten charts (EG, TR, TS, EN, JB, JD, CP, CD, CG-2 and LP) and compliance in six (DF, JR, EL, TMC, AB, GH).

		Recommendations: Address and correct factors related to inconsistent compliance with this requirement.
b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Findings**: The facility's chart audit data were limited to a review of the quarterly WRP schedule. The data indicate that 55% of the quarterly WRPs were held in a timely manner. In analyzing the data, the facility recognized the same error mentioned above. Most likely, WRPs that should have been marked as NA were marked as "No," inflating the number of "No" responses and decreasing the overall percentage of compliance. ASH has not implemented the WRP conference schedule, but continues to hold 90-day (quarterly) team conferences. This monitor reviewed 14 charts and found non-compliance in nine (MC, EN, KL, AB, BE, GP, CP, CD and MW) and compliance in five (JR, EG, JJ, GM, TE). **Recommendations:** 1. Same as above. 2. Ensure monitoring of bi-weekly, quarterly and monthly WRPs.
c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Findings:** The DMH WRP manual (7.3. Case Formulation, 7.5 Discharge Criteria, 7.6 Focus of Hospitalization, 7.7 Objectives and 7.8 Interventions) adequately addresses this requirement. ASH has yet to develop and implement a monitoring tool. Chart reviews by this monitor indicate that the WRPs of individuals

		suffering from seizure disorders and receiving older generation anticonvulsant medications (e.g. GM, LEM, PC, RP, CD and QW) are not assessed regarding the possible negative impact of treatment on the cognitive, behavioral and life quality of the individual. This is noted even for individuals who are diagnosed with cognitive impairment (QW). As a result, the WRPs do not include objectives/interventions to minimize this risk. In some cases, the WRPs fail to include any objectives or interventions for these individuals (e.g. GM, PC,RP, CD and QW) This monitor also reviewed charts of individuals suffering from a variety of Cognitive Disorders. This review revealed a pattern of deficiencies, including: 1. The WRPs fail to include the diagnosis as a focus or to include objectives and interventions for treatment and/or rehabilitation. Examples are found in the charts of NC (Dementia due to Traumatic Brain Injury), SO (Dementia due to Chronic Viral Infection), DA (Cognitive Disorder, NOS), GP (Dementia due to Neurosyphilis), DM (Dementia due to Multiple Medical Problems), TG (Dementia due to Parkinsonism) and RP (Mild Mental Retardation). 2. There is no evidence that proper interventions are provided when the foci of hospitalization objectives address cognitive deficits (RR). 3. In general, when interventions are included, there is no documentation of the individual's progress in treatment and its implication for further treatment and rehabilitation. The above examples indicate that the WRPs currently performed at ASH generally fail to comply with this requirement.

		Compliance: Partial. **Recommendations:** 1. Develop a new monitoring tool to assess the overall quality of the integrated elements in the WRP in order to adequately address this requirement. The review must be done only by clinicians. 2. Continue and strengthen training of WRP teams to ensure that: a) The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b) Foci of hospitalization addresses all identified needs of the individual in the above domains. 3. Develop and implement audit items to ensure that cognitive disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. 4. Develop and implement audit items to ensure that substance abuse, if present, is documented as a focus and that individualized and appropriate objectives and interventions are provided. 5. Develop and implement audit items to ensure that seizure disorders, if present, are documented as a focus and that individualized and appropriate objectives and interventions are provided. The documentation needs to address the interface between seizure disorders (and its treatment), psychiatric status (and its treatment) and psychosocial functioning of the individual.

d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Findings:** The facility has monitoring data based on chart reviews (quarterly WRPs) using the previously mentioned Case Formulation Form. The data indicate the following compliance rates: 1. Is the information (i.e., pertinent history, predisposing, precipitating, perpetuating factors, previous treatment and present status) aligned with the assessments? (11%). 2. Is the case formulation interdisciplinary (i.e., does the information reflect participation by all relevant disciplines? (5%). Chart reviews by this monitor corroborate the facility's low compliance rates. In general, the case formulations are not based on careful analysis of the information in the assessments. Almost all the charts reviewed demonstrate a pattern of significant deficiencies in the quality/content and completeness of case formulations. The key deficiencies include: 1. The case formulations are not consistently completed in the 6-p format (pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status). 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci

		of hospitalization, life goals, objectives and interventions). 5. The information in the case formulations does not provide the basis for proper delineation of diagnosis and development and finalization of a differential diagnosis. These deficiencies are such that the current case formulations performed at ASH generally fail to address the requirement in this step. This finding is also applicable to C.2.d.ii through C.2.d.i.v. **Recommendations:** Continue and strengthen training of the WRP teams to ensure that the case formulation adequately addresses the requirements in C.2.d.
d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	**Findings**: Using the above-mentioned process, the facility reports an overall compliance rate of 9% with this requirement. The following are the rates for each section of the case formulation: 1. Pertinent history: 12%; 2. Predisposing factors 8%; 3. Precipitating factors: 5%; 4. Perpetuating factors: 5%; 5. Previous treatment history: 11%; and 6. Present status: 11%. **Recommendations:** Same as above.
d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above	The facility reports a compliance rate of 6% with the requirement that the case formulation includes a review and analysis of important clinical factors across multiple domains (medical, psychiatric, behavioral, functional status and quality of life) that are relevant to the WRP.

		Recommendations: Same as above.
d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	**Findings**: The facility reports a compliance rate of 6% based on the same review process. **Recommendations:** Same as above.
d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	**Findings:** ASH reports 0% compliance with the requirements that the case formulation documents completion of the DSM-IV-TR checklist and that the completed checklist supports the given diagnosis. **Recommendations:** Same as above.
d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	**Findings:** The facility reports the following compliance rates corresponding to the monitoring indicators. The indicators appropriately address the different components of this requirement. 1. Does the present status section of the case formulation adequately summarize the needs of the individual in the three domains: treatment, rehabilitation, and enrichment? (8%). 2. Does the case formulation identify required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes? (2%). 3. Does the case formulation predict the discharge setting? (2%). 4. Is there evidence of proper analysis of information? (2%). 5. Is there proper linkage within different sections of the formulation? (3%).

		6. Does the case formulation account for strengths of the individual and the system? (3%). **Recommendations:** Same as in C.2.c, C.2.f, C.2.g and C.2.o.
e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Findings:** The facility used the Chart Auditing Form to assess compliance with this requirement. The data indicate 14% compliance with the indicator stating that the therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals / objectives (interventions). Chart reviews by this monitor indicate that, in almost all cases, the foci of hospitalization are incomplete, usually limited to one or two areas, are identified in generic terms and do not offer meaningful targets for treatment, rehabilitation and enrichment of the individuals. Deficiencies are noted in the following areas: 1. Identification of foci of hospitalization that address individuals' special needs (see monitor's findings in C.2.c and C.2.o). 2. Proper formulation and execution of objectives and interventions (see the monitor's findings in C.2.f.i through C.2.f.vii). 3. Appropriate revision of foci and objectives (see the monitor's finding in C.2.g). **Compliance:** Partial.

		Recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.
f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	**Compliance:** Partial.
f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Findings**: Using the same chart audit system, the facility reports 29% compliance rate with this requirement. This monitor reviewed five charts to assess compliance. This review demonstrated inconsistent practice, with failure to meet the requirement in three cases (RA, CG-1 and JO), partial compliance in one (JJF) and compliance in one (ATM). **Recommendations:** Continue and strengthen training of WRP teams to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.
f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Findings**: The facility's chart audit data indicate 2% compliance with this requirement. Reviews of five charts by this monitor demonstrate non-compliance with the requirement in four cases (ATM, RA, CG and JO) and partial compliance in one (JJF).

		Recommendations: 1. Same as in C.2.f.i. 2. Same as in C.2.e.
f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Findings:** ASH's data indicate 44% compliance with this requirement. The monitoring indicator appropriately states that the WRP includes behavioral, observable, and / or measurable objectives written in terms of what the individual will do. Chart reviews by this monitor show non-compliance in three cases (RA, CG, JO) and partial compliance in two (ATM, JJF). **Recommendations:** Same as in C.2.f.i
f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Findings**: The facility's chart audit data indicate zero% compliance with this requirement. Case reviews by this monitor (JJF, RA, CG-1, ATM and JO) show non-compliance in four charts due to failure to identify any stages of change or to include an adequate outline of the stages. Partial compliance is noted in one chart (ATM). **Recommendations:** 1. Same as in C.2.f.i. 2. Same as in C.2.e.

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<td>f.v</td>
<td>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</td>
<td>Findings:
The facility's chart audit sample indicates 25% compliance with this requirement.

Case reviews by this monitor show overall inadequate implementation of this requirement, with non-compliance in two cases (CG and JO), partial compliance in two (JJF and RA) and compliance in one (ATM).

Recommendations:
Same as in C.2.f.i</td>
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<td>f.vi</td>
<td>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</td>
<td>Findings:
ASH has yet to develop and implement an adequate system to assess its compliance with this requirement. The facility reviewed aggregate reports from Planned Scheduled Treatment (PST) database(s) and found inaccuracies in the system. The facility has recently completed a pilot of the statewide MAPP (My Activity Plan of Participation) system. At this time, one program (I) is using MAPP instead of PST and another program (VI) is transitioning to this system. The facility plans to use the information from this transition to finalize hospital-wide implementation plan for MAPP.

Chart reviews by this monitor demonstrate inadequate implementation of this requirement. The table below illustrates several examples. The examples reveal low compliance rates and disconnection between information in the WRP and the Patient Attendance Record (PAR) in the information regarding hours of active treatment scheduled.

<table>
<tr><th>Individual's Initials</th><th>Hours Scheduled (WRP)</th><th>Hours Scheduled (PAR)</th><th>Hours Attended (PAR)</th></tr>
<tr><td>SD</td><td>6.00</td><td>13.75</td><td>10.6</td></tr>
<tr><td>PJC</td><td>2.00</td><td>11.4</td><td>4.3</td></tr>
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		<table><tr><td>RA</td><td>3.25</td><td>16.2</td><td>8.3</td></tr><tr><td>MLD</td><td>0.25</td><td>6.4</td><td>3.1</td></tr><tr><td>JSC</td><td>7.50</td><td>27.3</td><td>11.3</td></tr><tr><td>JJF</td><td>8.00</td><td>16.5</td><td>3.00</td></tr><tr><td>JO</td><td>7.00</td><td>8.50</td><td>8.30</td></tr></table> **Recommendations:** 1. Assess and address the factors related to inadequate scheduling by the WRP teams and/or participation by individuals to ensure compliance with the requirement. 2. Monitor hours of active treatment scheduled and attended, using an adequate statewide system for data processing.
f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	**Findings**: The facility has chart audit data indicating 14% compliance with this requirement. This monitor's review of the charts of adult civilly committed individuals (SD, PJC, RA and MD) does not show evidence of activities that meet the requirement in this item. **Recommendations:** Assess and correct factors related to lack of programs.
f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Findings:** ASH does not have monitoring data that assess compliance with this requirement. All chart reviews conducted by this monitor demonstrate lack of documentation that supports linkage between Mall activities and objectives outlined in the WRP. As mentioned in C.2.f.iv, the WRPs' documentation of scheduled active treatment hours is inconsistent with the PARs. Personal interviews with staff psychiatrists confirm a

		disconnection between the WRP and interventions provided at the Mall. **Recommendations:** 1. Develop and implement a mechanism to ensure proper linkage between type and objectives of Mall activities and objectives outlined in the WRP as well as documentation of this linkage. 2. Revise the WRP/Mall Alignment Check Protocol to properly address this requirement. 3. Implement electronic progress note documentation by all Mall and individual therapy providers.
g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	**Compliance:** Partial.
g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Findings**: The DMH WRP manual does not include specific parameters for review and revision of the foci, objectives and interventions. ASH has data based on the previously described process using the DMH WRP Observation Monitoring Form. A compliance rate 10% is reported. As reported in C.2.e, this monitor found significant deficiencies in the formulation of foci of hospitalization. In addition, four charts were reviewed by this monitor to assess compliance with this requirement. Most of the charts reviewed (e.g. HTK, NC-2, GM and AI) demonstrated failure to revise the foci and/or objectives/interventions to reflect the individuals' changing needs.

		Recommendations: 1. Ensure that the DMH WRP manual contains specific requirements for review and revision of foci, objectives and interventions to address changes in the individual's status. 2. Continue and strengthen training to WRP teams to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed.
g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Findings**: ASH has chart audit data that show 5% compliance with this requirement. This monitor reviewed the charts of nine individuals that experienced restrictive interventions in the past year. This review indicated non-compliance in eight cases (VBT, WT, KEL, MW, HTK, NC-2, AI and JJC) and compliance in one (JJM). **Recommendations:** 1. Same as above. 2. Ensure that monitoring includes individuals whose functional status has improved.
g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Findings**: The facility reports 13% compliance rate based on process observation data. Chart reviews by this monitor (GD, MM, IH, LB and JWR) indicate a general trend of deficiencies in the following areas: 1. Identification of discharge criteria; 2. Team discussion of the individual's progress toward discharge; 3. Update of the present status section of the case formulation

		regarding the individual's progress; and 4. Revision of the interventions if no sufficient progress has been made toward discharge. **Recommendations:** 1. Continue and strengthen training to WRP teams to ensure consistent implementation of this requirement. 2. Ensure that the monitoring tool addresses the documentation of the results (of the team's review or progress) in the present status section of the case formulation and appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual).
g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Findings**: Facility's data show 8% compliance with this requirement based on chart audits. Chart reviews by this monitor demonstrate failure to conduct data-based reviews in the WRP in all cases (VBT, JJC, WT, KEL and MW). **Recommendations:** 1. Same as in C.2.g.i. 2. Same as recommendation #3 in C.2.f.viii.
h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	**Findings:** ASH does not have a method in place to evaluate the implementation of this task. ASH has one-half of a PBS team. This PBS team is very motivated to work within the Recovery Model and to fulfill all criteria of the EP. The team members were open to discussion and analysis of the current status of the PBS team and their function.

		The number of individuals on PBS plans is a fraction of those who can be expected to be on the plan, as evidenced by the high number of individuals (722) listed as having severe maladaptive behaviors, and the high number of individuals who have been managed for those behaviors through the use of crisis management and seclusion and restraint procedures. Thus, ASH needs the full complement of PBS teams to be able to serve all cases in need of PBS support. There are a number of serious concerns as to how the current PBS team functions within the hospital system and the barriers to full implementation of PBS plans, including: 1. Difficulty in training line staff due to lack of time and staff. 2. General lack of commitment by the unit staff to treatment implementation, integrity of implementation, and valid and reliable data collection. 3. PBS psychologists do not have the authority to write orders for the implementation of PBS plans. **Compliance**: Partial. **Recommendations:** 1. Increase the number of PBS teams as specified in the Enhancement Plan. 2. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 3. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 4. Provide competency-based training to all staff in PBS procedures, and provide on going training and support for PBS team members, as needed. 5. Ensure that all individuals whose severe maladaptive behaviors

		not amenable to change under unit behavioral guidelines are referred to the PBS teams for structural and functional analysis, and PBS supports. 6. Ensure that WRP Team members understand when they should refer individuals to the PBS team. 7. Ensure that WRP teams have a clear understanding when they should refer cases to BCC. 8. Ensure that there is full administrative support for PBS team functions.
i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Non-compliance.
i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Findings**: ASH does not have a method to track and monitor this task. ASH's psychosocial rehabilitation services are severely deficient. Observation of WRP team conferences showed that this task was not adequately addressed. The facilitators of the groups observed by the monitor indicated that about half the individuals scheduled to attend their groups stop attending after a few sessions. The facilitators did not know why these individuals failed to attend the groups, where they may be if not in the group, or if they were attending another group instead. The facilitator also did not communicate with the WRP teams on the status of the individuals with regards to their attendance. Further, no interventions including Motivational Interviewing, Narrative Restructuring Therapy and Cognitive-Behavioral interventions are used to change these individuals' attitudes and participation in their assigned group and individual therapies.

		The Mall Director has devised a tool that allows the individuals to choose groups of their choice with guidance from their WRP team. However, the Mall Director found, in many cases, that the teams failed to work with the individuals, but rather allowed the individuals to choose groups/activities without regard to their needs or discharge criteria. Many of the discipline-specific assessments failed to address the individuals' rehabilitation needs. **Recommendations:** 1. Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. 2. WRP teams should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs 3. Ensure that group leaders are consistent and enduring for specific groups. 4. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. 5. Track and monitor this objective.
i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Findings**: This monitor's review of 20 charts showed that a majority of objectives were not written in terms of objective and/or measurable outcomes. Many of the objectives were stated in the negative, i.e., what the individual will not do rather than what the individual will do. In addition: 1. At least 55% did not have documented objectives

		2. At least 10% had no WRPs in the chart. 3. At least 10% had more than one objective lumped together. 4. At least 15% had objectives and interventions that did not match. **Recommendations:** 1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. 2. Ensure that the learning outcomes are stated in measurable terms. 3. Ensure that each objective is directly linked to a relevant focus of hospitalization.
i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Findings**: The PSR Mall is supposed to be run according to the PSR Mall Manual. This is not the case. ASH has planned for and prepared manuals and curricula for a Psychosocial Rehabilitation Mall. At this time, group activities are conducted in units. And, for the most part, groups and other therapies are not aligned with the needs of the individuals. This monitor noted the following deficiencies: 1. Organization and structure vary widely across groups. 2. Goals are rarely made clear. 3. Functioning capacity of participants ranged widely within groups. 4. The objectives specified in the individuals' WRPs and the groups they are assigned to, as well as the contents of the groups, are not aligned with the individual's needs. 5. In some cases, the focus of the group is on the activity itself rather than the skills/education/training/ that the individual is to derive by attending the Mall group. The Mall Director is highly committed to the PSR Mall program.

		However, he has identified the following barriers to the process of implementing the program: 1. Poor cooperation from many personnel; 2. High turnover, posing discontinuity of providers; 3. Lack of automation causing difficulty with data analysis; 4. Workload limiting staff from getting training; 5. Use of residential unit rooms for Mall activities; 6. Lack of uniformity in curriculum, group types, goals and objectives among the seven programs; and 7. Providers, represented mainly by Recreational Therapists result in groups receiving 'activities' rather than 'treatment'. The Mall Director has identified solutions to many of these barriers. **Recommendations:** 1. Ensure that WRP teams write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided are aligned with the assessed needs of the individuals. 3. When assigning individuals to Mall groups, the WRP team members should be familiar with the contents of the group they recommend so that the groups are aligned with the individuals needs. 4. Group leaders should be held accountable to follow the Mall curricula. 5. The Mall Director needs administrative support to carry out his duties. 6. Ensure the Mall Director has the necessary staff to assist with Mall programming and management.
i.iv	utilizes the individual's strengths, preferences, and interests;	**Findings**: Chart reviews, group observations and WRPs showed very little attention to this item.

		ASH's self-assessment data identified only 3% compliance with requirement. **Recommendations:** 1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. 2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.
i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Findings**: At this time, ASH does not have a monitoring mechanism to assess compliance with this requirement. This monitor's review of WRPs and interviews with staff showed that the case formulation is inadequate in presenting or discussing an individual's vulnerabilities to mental illness and substance abuse (predisposing, precipitating and perpetuating factors). Chart reviews and staff interviews revealed that case formulation using the 6-p format is uneven in quality, has almost no analysis, and does not follow the content guidelines established in the DMH WRP Manual. Most of the case formulations are a cut-and-paste from old notes, which defeats the intent of the formulation in serving as the functional bridge between the assessments and the WRP. This monitor's reviews of WRPs show that, in general, there is not a clear focus of treatment on those factors that precipitated readmission due to relapse. There is almost no reference in the case formulation to an individual's vulnerability to relapse or evidence of objectives and interventions that are related to these vulnerabilities. The monitor's findings under C.2.n and C.2.o are also relevant to this

		section. **Recommendations:** 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Develop and implement a training curriculum to ensure proper implementation of the staged model of substance abuse by WRP teams. 5. Provide groups regarding the purpose of Wellness Recovery Action Plan to all individuals in order to preempt relapse. 6. Same as in C.1.d.i
i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Findings**: Groups are almost never assigned by cognitive levels. The current Mall groups observed by the Monitor presented with individuals with wide ranging cognitive levels. ASH does not have a tool to track and monitor this item. **Recommendations:** 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and	**Findings**: This monitor found no evidence of progress notes regarding group

	Recovery Plan review process	activities that can provide needed information to the WRP team. The DMH PSR Mall monthly progress note has not been implemented. ASH does not have a method to track and monitor this item. **Recommendations:** 1. Ensure that all group and individual therapy providers provide the WRP teams with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Findings**: The PSR Mall is not run according to the requirements of the EP This activity is not fully implemented for all individuals in the system. Mall group activities are provided in the individuals' residential units. Mall groups are conducted Monday through Friday, but only for two hours (9AM-11AM) in the morning in a structured format. Mall group activities when conducted in the afternoon do not comport with current professional standards. Interview of staff showed that many are unclear about Mall existence, activity, or their participation. None of the disciplines provide enough hours of service in the PSR Mall group activities. PST active treatment scheduled time ranges from 0.38 hours to 1.64 hours/day PST active treatment actual hours held ranged from .32 to .1.58 hours/day. PST active treatment attendance range from 0.16 hours to 0.94 hours/day. **Recommendations:** 1. Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e., two hours in the

		morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. 2. Mandate that all staff other than those who attend to emergency medical needs of individual's will provide services at the PSR Mall. This includes clinical, administrative and support staff. 3. All Mall sessions must be 50 minutes in length. Sessions less than 20 minutes do not contribute to an individual's active treatment hours. 4. Provide groups as needed by the individuals and written in the individuals' WRPs. 5. Add new groups as the needs are identified in new/revised WRPs.
i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Findings**: ASH does not have a method to track and monitor this item. ASH did not have any bed-bound patients for observation. ASH does not have a skilled nursing unit. Bed-bound patients are treated in the infirmary. **Recommendations:** 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status, medical, health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
i.x	routinely takes place as scheduled;	**Findings**: ASH is not fully adhering to a PSR Mall model of service delivery. To enable the Mall to be run properly, all residential units should be

		closed (except for a centralized unit for emergency medical care for individuals who are ill). All staff should be providing groups in the Mall. All disciplines should provide their required hours of service to the Mall activities. On average there is a 15% cancellation of scheduled group activities **Recommendations:** 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Findings**: The hospital's self-assessment reveals that PST records do not differentiate enrichment and treatment activities on weekends The average hours of enrichment activities are minimal. Very few structured enrichment activities are provided during the weekends. Per the Mall Director there are 7 independent programs with 7 different curriculums., lacking in quality, different groups have different plans, and usually not by needs of the individuals. **Recommendations:** 1. Develop a list of all enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal

		interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 4. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Findings**: Observation of the Milieu showed that positive affirmations about recovery were prominently posted around the units. Staff answered questions from individuals. Sixty percent of the individuals reported that the staff members were responsive when they were approached for information and support. ASH's audit data showed that 17% of the staff observed discussed Mall activities with individuals, only 5% of the staff in the therapeutic milieu were known to reinforce individuals, and 57% of the individuals surveyed indicated that the staff in the residential units spoke with them on what they were learning in Mall groups. **Recommendations:** 1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. 2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well in the units.
j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Findings:** ASH only has one program using the MAPP currently. Enrichment and group and recreational activities are not provided in sufficient variety

		and quantity to meet the needs of all the individuals. ASH has a significant percentage (78%; 117 of the 152 measured) of individuals with a BMI of 25 or greater who would benefit immensely with increased and varied exercise and recreational activities. **Compliance:** Partial. **Recommendations:** 1. Establish group exercises and recreational activities for all individuals. 2. Ensure that there is sufficient programming of activities for individuals to engage to keep them active and engaged. 3. Provide training to Mall facilitators to conduct the activities appropriately. 4. Track and review participation of individuals in scheduled group exercise and recreational activities. 5. Implement corrective action if participation is low.
k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Findings:** ASH does not provide any formal family therapy services at this time. ASH also does not have a tracking system in place to identify individuals needing family therapy services. The Director of Social Work services reported that social workers attend to the needs of individuals and, where applicable, contact families via phone. There were no discussions during WRP conferences with individuals on their need for family therapy. None of the social work notes in the charts reviewed had any notation

		on family therapy for individuals. The Director Social Work shared with the monitor the Social Work Department's previous work on needs assessment on family therapy services. The previous model of family therapy with a few adaptations can be made to meet the criteria for this item. **Compliance:** Non-compliance. **Recommendations:** 1. Conduct a needs assessment with individuals and/or their families. 2. Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. 3. Review pre-admission reports and services/treatments provided to identify the need for family therapy services. 4. Ensure that family therapy needs are fulfilled.
l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Findings:** ASH does not have a monitoring instrument to address ths requirement. **Compliance:** Non-compliance. **Recommendation:** Develop and implement a monitoring instrument and a system to track the elements of this EP requirement.

m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	ASH does not have this population in the facility.
m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	Not applicable.
m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	Not applicable.
n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Findings:** California DMH has developed a draft policy regarding Screening for Substance Abuse. The policy provides guidelines and responsibilities for the appropriate screening of all individuals as clinically indicated. The procedures do not address one of the two main purposes of the policy, that is to ensure that screening and assessment of substance abuse is available and used to provide therapeutic and rehabilitation services that are consistent with generally accepted professional standards of care. At this time, ASH does not have policies and procedures that specifically ensure appropriate screening for substance abuse issues by the WRP teams. However, the facility has a directive developed by the Substance Abuse Central Program Services (CPS) that guides Substance Abuse Services (SAS) staff in screening for substance abuse issues once a referral has been received from the WRP teams. The screening/assessment appears to meet generally accepted professional standards of care. **Compliance:** Partial. **Recommendations:** 1. Revise the DMH draft policy regarding Screening for Substance Abuse to address all purposes of the policy. 2. Finalize and implement the policy and procedure.

o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Findings:** The facility has data indicating that as of September 6, 2006, 961 0f 1270 individuals (76%) at ASH had a substance use-related diagnosis. There is a Substance abuse Services (SAS) Program that provides services to many of these individuals. The SAS program has a philosophy consistent with the trans-theoretical model as outlined in the **Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual** by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch, and Carlo C. DiClemente. This is an excellent, evidence-based manual that comports with current generally accepted standards of care in the field. The majority of services are provided through Central Program Services (CPS). The services are structured around an individual's stage of change, cognitive level of functioning, and the individual's choice of approach to substance abuse treatment. Referrals to SAS are generated by an individual's WRP team. SAS currently has the capacity to serve 160 individuals a quarter, not including Alcoholics and Narcotics Anonymous (AA / NA) groups. AA / NA groups are offered through SAS to all individuals at ASH in both English and Spanish. Regarding referrals of individuals with forensic issues, the WRP teams currently refer individuals with MDO (Mentally Disordered Offender-PC-2962), SVP (Sexually Violent Predator-6602 WI), NGRI (Not Guilty by Reason of Insanity-PC 1026), and MDSO (Mentally Disordered Sex Offender-6316 WI) commitments. Referrals are not accepted for individuals who are under PC 1370 (Incompetent to Stand Trial) and PC 2684 (Referral from Department of Corrections) commitments due to their short length of stay and that substance abuse issues are not barriers to discharge for these individuals.

		Individuals identified as being in the pre-contemplative stage of change receive their SAS from staff in the residential programs (in those Programs that have transitioned to the Mall model i.e. Programs II, IV and VI). Individuals under PC 1370 and 2684 commitments do not receive these services. Most of these groups use material provided by SAS for pre-contemplative individuals. Program IV also uses a Relapse Prevention–oriented manual. Program V offers an introductory level, educational course on substance abuse to individuals under PC 2684 commitment. The SAS program has yet to develop and implement a formalized training curriculum to ensure proper implementation of the model by the WRP teams. ASH does not currently have a tracking system in place to determine how many individuals with substance-related diagnoses have received or are receiving substance abuse. Using the Substance Abuse Monitoring Tool, the facility conducted chart audits of a randomly selected sample of 157. The sample represented 21% (157 of 743) of the new WRPs of individuals with a substance abuse-related diagnosis. The audit was completed by one of the Assistant Chiefs of CPS during September 2006. The compliance rates for each audit item are outlined as follows: 1. When Substance Abuse is diagnosed on Axis I, is it documented in Focus #5 (Substance Abuse)? (85%) 2. Substance abuse is identified in the 6 Ps. (97%) 3. Is there an objective and corresponding intervention under focus #5? (77%) 4. Is the individual's stage of change identified in the WRP? (76%) 5. Is the stage of change consistent with corresponding

		objectives and interventions? (76%) ASH does not currently have a tracking system in place to determine how many individuals with substance-related diagnoses have received or are receiving substance abuse treatment. Chart reviews by this monitor (JR, DG, LB, MM and IH) indicate a general pattern of deficiencies in the following areas: 1. Presence of a WRP that recognizes substance abuse (JR and DG); 2. Failure to include substance abuse as a focus for hospital-ization when the diagnosis is made ((LB); 3. There are no objectives or interventions listed when the diagnosis of substance abuse is identified as a focus for hospitalization (LB); 4. Failure to address substance abuse in the formulation of discharge criteria (JWR) 5. Delay in the provision of substance abuse services due to inadequate follow-up by the WRT on the status of referral (MM). 6. There is no evidence of recovery-based interventions due to either failure to identify stages of change for the individual (e.g. MM) or inappropriate identification of those stages (MM, GD, IH). This finding is inconsistent with the hospital's data regarding the identification of stages of change for individuals with substance abuse; 7. There is no evidence of recovery-based interventions when the stages of change are identified (IH). Furthermore, in the majority of charts reviewed by this monitor, the case formulations do not address the factors that precipitate or predispose, or perpetuate relapse and readmission and the WRPs do not address the interventions needed to overcome these factors.

		Compliance: Partial. **Recommendations:** 1. Standardize the substance abuse auditing mechanisms across all state facilities. 2. Develop and implement training curriculum to ensure proper implementation of the trans-theoretical model by all WRP teams. 3. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 4. Ensure that individuals under PC 1370 and PC 2684 receive substance abuse services based on their assessed needs.
p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Findings:** All staff credentials were reviewed with Ms. Susan Cahill, Staff Service Analyst. Per Ms. Cahill's report and available records it showed that all staff at ASH is properly licensed, certified, and credentialed. Those under other categories including provisional status are under proper supervision, training, and oversight. ASH's self-assessment data on staff credentialing is in agreement with Ms. Cahill's report. In general, there is a lack of match between facilitators and groups, except for a few like the Substance Abuse group. It appears that programs decide on who runs the various groups, and clinicians run groups in terms of what they like. ASH does not have a system in place to evaluate the competency of group facilitators. A number of scheduled group activities for observation by the monitor were cancelled. Among the groups observed, the anger

		management and communication skills groups were well organized and conducted. The group facilitators evidenced competency in the groups they were conducting. There is no self evaluation data to indicate that Facilitators monitor individual's responses to therapy and rehabilitation. **Compliance:** Partial. **Recommendations:** 1. Monitor the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives.
q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Findings:** Review of core program substance abuse service, new employee competency training workbook, substance abuse certification of group facilitators: Core program substance abuse service, new employee competency training workbook, and ASH self-assessment (April, 2006-September, 2006) showed that: ASH has 10 Substance Abuse Counselor positions and two of the positions are not yet filled. Among the eight Substance Abuse Counselors at ASH, two have formal certification, two have specialized training, and four others are receiving training within ASH. The ASH Substance Abuse training curriculum is similar to community training programs, and therefore should serve as the basis for substance abuse facilitator certification as long as the trainers are certified and or licensed. Providers of Substance Abuse counseling to

		individuals in the pre-contemplative stage have not met competency **Compliance:** Partial. **Recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators. 5. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH Substance Abuse counseling competency.
r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Findings:** ASH does not have any transportation issues. Their self-assessment data showed 99% compliance to this item. ASH does not have an automated system to track missed appointments. **Compliance**: Substantial. **Recommendations:** 1. Establish an automated system to track cancellation of scheduled appointments. 2. Continue to improve on ensuring that all medical appointments of individuals are completed as scheduled.
s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are	**Findings:** ASH's Mall structure is not in line with EP requirements.

	assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	The Mall concept and activities have not been implemented in all programs and units. Mall hours and the number of enrichment hours, both on weekdays and weekends, are insufficient. Group assignments do not take into account individuals' cognitive levels. ASH does not have a monitoring tool to track this item. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering groups assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements. 4. Implement PSR Mall in all Programs in the facility.
t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Findings:** ASH currently does not have a tool to track this item. The Mall Director is in the process of establishing a tool for this purpose. Much of the Mall Director's work is on hold due to shortage of staffing, resource, and training of unit staff. **Compliance:** Non-compliance. **Recommendations:** 1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. 2. Develop and implement monitoring tools to ensure that Mall

		activities are properly linked to the foci, objectives and interventions specified in the WRP. 3. Ensure that all staff are fully trained 4. Implement PSR Mall to all Programs in the facility.
u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	**Findings:** ASH is in the process of developing a 12-week lesson plan for Mall-based groups—"Introduction to Wellness and Recovery"--but has yet to implement it. Currently, ASH does not have a tracking system to monitor whether individuals are provided copies of their WRPs. **Compliance:** Non-compliance. **Recommendations:** 1. Provide Mall groups to address this requirement. 2. Ensure that the Mall group curriculum includes and identifies groups that offer education about the purpose of treatment, rehabilitation and enrichment activities. 3. Develop and implement a monitoring tool to address this requirement. 4. Ensure that individuals are provided a copy of their WRP based on clinical judgment.
v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Findings:** The DMH WRP does not include guidelines for WRP Teams to assist individuals in making choices based on need and available services. All programs except for one (Program I) are currently offering medication management groups. There are currently 13 active medication management groups held in the facility. All of the groups take place on the programs; none are held on the Mall. The groups are provided by health services specialists, staff psychiatrists, registered nurses and psychiatric technicians.

		As of October 19, 2006, 451 of 1209 individuals housed at the facility have attended a Medication Management class during their time at ASH. Currently, 160 of 1205 individuals are assigned to a medication management group. A Patient/Family Health education records audit performed from 10/20-10/24/2006 shows that 242/250 of the charts audited reflected that the individual received medication teachings at least once. It is noted that the Patient/Family Health Education Record is not adequate in monitoring medication education compliance. At this time, ASH does not have a system to track the attendance and participation by individuals in medication classes and to assess whether these groups are sufficient to meet the clinical needs of individuals. Furthermore, the facility does not have a mechanism to ensure that the individuals' needs are assessed in this regard and to assist individuals to make choices based on both needs and available services. **Compliance:** Partial. **Recommendations:** 1. Provide Mall groups that offer education regarding medication management. 2. The DMH WRP manual needs to include guidelines to WRP teams regarding the assessment of individuals' needs regarding this requirement and to assist individuals in making choices based on both need and available services.
w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Findings:** At this time, ASH does not have a monitoring mechanism to assess its compliance with this item. The facility does not have a mechanism to

		track participation by the individuals in their WRPs. The WRP teams do not have a methodology to assess individuals' barriers to participation. In addition, the WRP teams do not provide individuals with clinical strategies to help them achieve readiness to engage in group activities. **Compliance:** Partial. **Recommendations:** 1. Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP. 2. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. 3. Ensure that the DMH WRP manual includes guidelines to WRP teams regarding assessment methodology and strategies, including cognitive interventions, to facilitate individuals' participation. 4. Develop and implement monitoring tools to assess compliance with this item.

D	**Integrated Assessments**	
	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress**: 1. With the exception of psychiatric services, ASH is transitioning to a new system of integrated assessment. When fully implemented, the system provides comprehensive assessments of the individual's needs and serves as the basis for meaningful recovery model of service planning. 2. In general, the admission medical assessments, psychiatric reassessments and the transfer assessments are completed in a timely manner. 3. ASH has developed and, in some cases, implemented a variety of monitoring instruments that are aligned with the requirements in the EP. 4. In general, the facility's monitoring data reflect the integrity of the self-assessment process (e.g. psychiatric assessments and reassessments).
1	**Psychiatric Assessments and Diagnoses**	
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed Jeanne Garcia, M.D., Assistant Medical Director. Interviewed six Staff Psychiatrists. Reviewed charts of 26 individuals (DF, JR, EG, ZS, TS, EL, JJ, MAC, EN, GM, TC, DG, RG, TR, JWB, AE, JHC, ELA, JH, VC, NC, LB, LLB, JLB, WAC and WC). Reviewed a roster of all psychiatrists at ASH and their board certification status. Reviewed the Central Medical Services Admission Medical Evaluation and Treatment Monitoring Form. Reviewed form regarding Application for Appointment to the Medical

		Staff. Reviewed ASH Medical Staff Bylaws, Rules and Regulations. Reviewed the Department of Psychiatry Procedure Manual. Reviewed Psychiatry Peer Review Audit Worksheet. Reviewed ASH AD #516.7 regarding Screening for Possible Movement Disorders Related to Neuroleptic Medication. Reviewed Tardive Dyskinesia Monitoring Form. Reviewed Admission Medical Evaluation and Treatment Monitor Tool. Reviewed Admission Medical Evaluation and Treatment Monitor Summary Data (June to August 2006). Reviewed Psychiatric Evaluation Monitoring Form. Reviewed Psychiatric Evaluation Monitoring Summary Data (April to September 2006). Reviewed Psychiatry Monthly Progress Note Monitoring Form, Reviewed Psychiatry Monthly Progress Note Monitoring Summary Data (September and October 2006). Reviewed Transfer Assessment Monitoring Summary Data (October1, 2006). Reviewed a list of all individuals at ASH, including name, diagnoses, current medications, name of attending physician and unit of residence.
a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Findings:** ASH has yet to implement a monitoring mechanism to assess its compliance with this requirement. ASH provides copies of the most current DSM to all hospital units and all psychiatrists and psychologists. The DSM-IV Symptom Checklist has been placed on each unit for clinician use. ASH has yet to implement a monitoring mechanism to assess its compliance with this requirement. Chart reviews by this monitor indicate that, by-and-large, psychiatric diagnoses are stated in terminology that is consistent with the current

		version of DSM. However, the facility has yet to implement the requirement regarding integrated psychiatric assessments. The quality of the admission psychiatric assessments is inconsistent and the information needed for adequate diagnostic formulations is either missing or does not provide the basis for reaching the most reliable diagnosis. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a monitoring instrument to assess accuracy/validity of psychiatric diagnoses. 2. Standardize the monitoring forms, sampling methods and other mechanisms of internal monitoring across state facilities. Ensure that compliance rates derived from internal monitoring are based on a review of at least 20% sample monthly stratified by physician/psychiatrist. This recommendation is relevant to all applicable items in section D.
b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	**Compliance:** Partial.
b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Findings**: Records of ASH indicate that the facility currently employs 27.5 FTE Staff Psychiatrists in addition to the facility's Medical Director and Assistant Medical Director (Senior Psychiatrist Supervisor). Review of the facility's staff vacancy data indicates that the vacancy rate for psychiatrists is 57%. In addition to Staff Psychiatrists, the facility employs eight FTE Psychiatric (Mental Health) Nurse Practitioners that provide care under supervision of the psychiatrists. All psychiatrists completed at least three years of psychiatry

		residency training in an accredited program. ASH requires that all applicants for psychiatry positions present documentation of satisfactory completion of psychiatry residency program approved by the ACGME Residency Review Committee (or osteopathic equivalent). The roster of staff psychiatrists indicates that approximately 77% of staff is board-certified. **Recommendations:** Continue current practice and encourage all psychiatrists to obtain board certification.
b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Findings:** The Assistant Medical Director reports that the facility has an interview process to assess the competency of applicants for psychiatry positions. The interview panel consists of the Medical Director, an Equal Employment Opportunity (EEO) representative and a member of the medical staff. The panel uses a list of standard questions including the role of psychiatrists in the interdisciplinary team process, assessment and treatment strategies, knowledge of the recovery model, risks of medications and clinical reasoning in medication strategies. ASH does not currently have record of this questionnaire. The initial application process includes a requirement to submit three letters of reference, two of which must be from peers who have knowledge of current competence and a primary verification phone contact of the source. The facility has a credentialing process that begins with an interview with a credentialing panel consisting of the chair of the department of psychiatry and other members of the medical staff including a representative of the credentialing committee. There is a reappointment process that reportedly incorporates results of the facility's current peer review system. The indicators used

		address psychopharmacology, diagnostic assessment, clinical management, leadership and team management, documentation, psychiatry medical staff obligations and committees and forensic reports. In general, this system contains an adequate outline for an effective peer review process, but the content of the indicators is not clearly and adequately aligned with requirements of the EP. The facility has a Department of Psychiatry Procedure Manual. The manual does not include the monitoring forms for admission and integrated assessments and psychiatry progress notes as well as instructions regarding their use. **Compliance:** Partial. **Recommendations:** 1. Refine quality indicators to be used in the performance evaluations/peer reviews of Staff Psychiatrists and ensure that the indicators clearly address the requirements of the EP, including the areas of diagnosis, assessment and reassessment. 2. Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and the content of all assessments and reassessments as required by the EP.
c	Each State hospital shall ensure that:	**Compliance:** Partial.
c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Findings**: The Medical Staff Rules & Regulations include a statement that the admission history, physical examination, and psychiatric evaluation shall be completed within 24 hours.

		ASH has developed and implemented an Admission Medical evaluation Treatment Monitor Tool. Using this tool, the facility conducted reviews (by peer physicians and surgeons) to assess its compliance with the requirement. The facility reviewed a sample of charts of new admissions each month from June to August 2006 (10 of 129 for June, 10 of 111 for July, and 10 of 141 for August of 2006). The sample ranged from 7% to 9%. The facility's data indicate an overall compliance rate of 97%. The compliance rates for each section in D.1.c.i.1 through D.1.c.i.5 are reported below. As a result of this monitor, the facility revised its form to ensure better alignment with the requirements of the EP This monitor's review of 15 charts corroborates the facility's data regarding the timeliness of the medical assessment (DF, JR, EG, ZS, TR, TS, EL, JJ, MAC, EN, GM, TC, DG, RG, and JWB). However, this review reveals much lower compliance rates for the content components. The following are examples: 1. The examination of the rectum was deferred (JWB) without follow-up. 2. The neurological examination was incomplete (EG, TR, ZS, EL, TS and EN), including individuals with neurological conditions that necessitated a complete examination (TR and EN). 3. The examination of genitals was deferred (due to individual's refusal) without follow-up (JR and EL). **Recommendations:** 1. Ensure completeness of the admission medical examination within the specified time frame. 2. Ensure that there is a rationale for deferral of items on the examination and that deferred items are subsequently addressed to ensure compliance with the intent of this item. 3. Ensure that monitoring of the admission physical examination

		addresses completeness of the examination and that the overall compliance rate accounts for the content and quality of each item.
c.i.1	a review of systems;	97%.
c.i.2	medical history;	97%.
c.i.3	physical examination;	97%.
c.i.4	diagnostic impressions; and	93%.
c.i.5	management of acute medical conditions	97%.
c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Findings:** The facility used the Psychiatric Evaluation Monitoring Form to assess its compliance with this requirement. The Assistant Medical Director (Senior Psychiatrist Supervisor) reviewed different samples of charts from admissions during April to June 2006 to assess compliance with each component in this section. The samples and compliance rates varied for each component of this section as outlined below. In addition, the facility reports a compliance rate of 99% based on a review by nursing staff at Program I of all charts (April to September) to assess whether a psychiatric assessment was present within 24 hours of admission. The review does not address the completeness and quality of the assessment. Reviews by this monitor of the above mentioned 15 charts demonstrate lower compliance rates for the completeness and quality of the components of the assessment. The following are examples: 1. There is evidence of incomplete mental status examination in most charts. The missing components include such essential

		items as cognition (DF) and nature of delusions and/or auditory or visual hallucination (e.g. JR and TC). 2. The assessment of strengths is inadequate for the purpose of Wellness and Recovery Planning (EG and EL). 3. The admission risk assessment is inadequate (ZS, TR and EG). Although the risk assessments are present in most of the charts that this monitor reviewed, these assessments, by and large, do not include important information regarding how recent the risk is, the relevance of risk to current dangerousness, the assessment of mitigating factors and planned interventions to reduce the risks. 4. The plan of care is generic, including individuals (e.g. ZS) who are identified to be a current risk for suicide. 5. In general, the assessment of insight is vague and subjective. 6. In general, the diagnostic formulation and differential diagnoses are inadequate. This deficiency is noted even in individuals who are in most need for this assessment. Examples are individuals who are receiving diagnoses listed as not otherwise specified (NOS). 7. The facility considers these assessments as Integrated Psychiatric Assessments. This is a deficiency because the assessments are completed within 24 hours, which is appropriate, but there is currently no additional mechanism to integrate data from collateral sources and other disciplines that become available during the first week of admission. Two of the charts reviewed (TS and GM) were in compliance with the requirement regarding the quality of the initial psychiatric assessments. **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Recommendations:
1. Ensure that the mental status examinations are completed on all admission psychiatric assessments.
2. Update the Department of Psychiatry Manual to include the requirements regarding D.1. c.ii.1 through D.1.c.ii.6.
3. Continue the practice of monitoring the admission psychiatric examination for timeliness, completeness and quality and ensure that overall compliance rate accounts for the completeness and quality of each item.
4. Ensure that psychiatric assessments include appropriate information regarding consultation referrals (for psychiatric/ neurological issues).
5. Implement a mechanism to comply with the requirement regarding Integrated Psychiatric Assessments.</td></tr>
<tr><td>c.ii.1</td><td>psychiatric history, including a review of presenting symptoms;</td><td>The rater reviewed chart samples of admissions during April to June 2006. The samples varied from 11% (10 of 91) to 31% (31 of 99). Results indicated that 100% of charts contained a history of present illness and that 88% met requirement for quality compliance.</td></tr>
<tr><td>c.ii.2</td><td>complete mental status examination;</td><td>The rater reviewed 22 of 92 admission assessments in September 2006. The compliance rate for each component of the mental status examination were as follows:

<table><tr><th>Component</th><th>Compliance rate</th></tr><tr><td>Attitude/Cooperation</td><td>100%</td></tr><tr><td>General Appearance</td><td>100%</td></tr><tr><td>Motor Activity</td><td>91%</td></tr><tr><td>Speech</td><td>86%</td></tr><tr><td>Mood/Affect</td><td>77%</td></tr></table></td></tr>
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<tr><td></td><td></td><td>
<table>
<tr><td>Thought Process/Content</td><td>96%</td></tr>
<tr><td>Perceptual Alterations</td><td>96%</td></tr>
<tr><td>Alertness</td><td>77%</td></tr>
<tr><td>Orientation</td><td>82%</td></tr>
<tr><td>Memory</td><td>77%</td></tr>
<tr><td>Attention</td><td>77%</td></tr>
<tr><td>Fund of General Knowledge</td><td>68%</td></tr>
<tr><td>Abstraction Ability</td><td>64%</td></tr>
<tr><td>Judgment</td><td>73%</td></tr>
<tr><td>Insight</td><td>77%</td></tr>
<tr><td>Folstein MMSE</td><td>90%</td></tr>
</table>
</td></tr>
<tr><td>c.ii.3</td><td>admission diagnoses;</td><td>The rater reviewed the same sample as above and found the following compliance rates for each corresponding component of this requirement:
1. DSM-IV-TR Address five axes: 91%;
2. Diagnostic formulation: 59%;
3. Included the diagnostic criteria for the given diagnosis: 59%; and
4. Addressed findings which may support other diagnosis: 23%

Although the rater found 20 of 22 assessments with reasonably accurate DSM-IV-TR 5 axis diagnoses, less than 60% of the assessments were justified in the formulation and/or included sufficient diagnostic criteria; and less than 23% considered findings supporting differential diagnoses.</td></tr>
<tr><td>c.ii.4</td><td>completed AIMS;</td><td>The facility has an AD (#517) that requires the performance of AIMS on each individual upon admission, annually and as needed. The Psychiatric Nurse Practitioners conducted a review using the Tardive Dyskinesia Monitoring Form to assess the facility's compliance with</td></tr>
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		this requirement. The raters reviewed 220 charts on 34 hospital units in September 2006 and found a compliance rate of 85%.
c.ii.5	laboratory tests ordered; and	ASH used the Admission Medical Evaluation and Treatment Monitor Tools and found a compliance rate of 97% with this requirement.
c.ii.6	consultations ordered.	Using the above process, the facility found 97% compliance rate regarding medical consultations. The facility also used the Psychiatric Evaluation Monitoring Form to assess compliance. In this process, the rater reviewed 125 of 638 admission psychiatric assessments. However, the results do not clearly indicate a compliance rate with the requirement as it applies to psychiatric care.
c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Findings:** ASH has yet to implement this requirement. The staffing shortage is a major barrier at this time. The facility reports the above-mentioned monitoring data for the admission psychiatric assessment. These data do not apply to this item. **Compliance:** Non-compliance. **Recommendations:** 1. Same as recommendation #5 in D.1.c.ii. The assessment must integrate information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. 2. Update the Department of Psychiatry Manual to include the requirements regarding D.1. c.iii.1 through D.1.c.iii.10. 3. Develop and implement monitoring tool of the integrated psychiatric examination to address timeliness, completeness and quality of the examination.

c.iii.1	psychiatric history, including a review of present and past history;	As above.
c.iii.2	psychosocial history;	As above.
c.iii.3	mental status examination;	
c.iii.4	strengths;	As above.
c.iii.5	psychiatric risk factors;	As above.
c.iii.6	diagnostic formulation;	As above.
c.iii.7	differential diagnosis;	As above.
c.iii.8	current psychiatric diagnoses;	As above.
c.iii.9	psychopharmacology treatment plan; and	As above.
c.iii.10	management of identified risks.	As above.
d	Each State hospital shall ensure that:	**Compliance:** Partial.
d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Findings:** The facility used the Psychiatry Monthly Progress Note Monitoring Form to assess compliance with this requirement. The Medical Director reviewed two randomly selected charts on each of 34 hospital units for the presence and content of the required monthly reassessments in September and October 2006. The review showed an overall compliance rate of 71% with this requirement. This monitor reviewed the charts of individuals that had diagnoses listed as NOS and/or R/O. Examples include JHC (Psychosis, NOS), ELA (Mood Disorder, NOS and Psychotic Disorder, NOS), JH (Dementia, NOS, Borderline Intellectual Functioning and Mild Mental Retardation), AE (Cognitive Disorder, NOS), LJ (Mental Disorder due to Multiple Aetiologies) and VC (Mental Disorder, NOS due to Multiple Head Injuries). In general, the reviews showed inadequate assessment, justification and updates of a variety of diagnostic categories.

		Recommendations: 1. Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders. 2. Revise current monitoring process to address justification of diagnosis, differential diagnosis and updates of diagnoses, particularly those listed as NOS, as appropriate.
d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Findings**: The facility's monitoring data are the same as in D.1.c.ii.3. This monitor's findings under D.1.a. and D.1.d.i are also applicable to this item. **Recommendations:** Same as D.1.a and D.1.d.i.
d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Findings**: At present, ASH does not monitor this item. This monitor found non-compliance as indicated by chart reviews listed under D.1.d.i. These findings were based on the review of the charts of seven individuals (JHC, JH, ELA, AE, LJ, VC and ELA) that had diagnoses listed as NOS or R/O. **Recommendations:** Same as D.1.d.i.
d.iv	"no diagnosis" is clinically justified and documented.	**Findings**: The facility's monitoring data are the same as in D.1.c.ii.3. **Recommendations:** Same as above.

e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Findings:** Using the Psychiatry Monthly Progress Note Monitoring described above, the facility reports 50% compliance with the requirement regarding weekly reassessments if length of stay is less than 60 days. The facility does not have data regarding the frequency of reassessments after the first 60 days of admission. This monitor reviewed the charts of five individuals with more than 60 days length of stay. The review showed compliance in four charts (NC, LB, LLB and JLB) and noncompliance in one (WAC). **Compliance:** Partial. **Recommendations:** 1. Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days. 2. Ensure monitoring of the requirement as written.
f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Findings:** Using the Psychiatry Progress Note Monitoring noted above, ASH assessed its compliance with items f.i. through f.v.ii. Under each of the EP items, the facility's monitoring indicators and corresponding compliance rates are listed below as relevant to the requirement. In almost all the charts reviewed by this monitor, there is a pattern of reassessments that do not meet the required elements. In general, the reassessments show the following deficiencies: 1. The assessment of interval events is lacking and does not adequately cover significant clinical developments. Most of the reassessments are cross-sectional and more oriented towards current crisis events.

		2. The diagnoses are not updated in a timely manner. As mentioned earlier, there is little justification for diagnoses listed as not otherwise specified and the diagnostic formulations and differential diagnoses are not adequate when needed. There is little or no documentation to indicate that the psychiatrist has used information regarding the individual's response to specific treatments as data to refine diagnosis. 3. The risks and benefits of current treatments are not reviewed in a systematic manner. 4. The assessment of risk factors is limited to some documentation of crises that lead to use of restrictive interventions. There is no evidence of proactive evaluation of risk factors or timely and appropriate modification of interventions in order to minimize the risk on an ongoing basis. 5. There is limited or no documentation of actual and/or potential side effects of benzodiazepines, anticholinergic medications and/or new generation antipsychotics. This pattern is noted even when these medications are used in individuals who are particularly vulnerable to the risks. 6. There is no review of the specific indications for the use of PRN or Stat medications, the circumstances for the administration of these medications or the individual's response to this use. Ultimately, the regular treatment is not modified based on the use of PRN or Stat medications. 7. When behavioral interventions are provided, there is no documentation to indicate an integration of pharmacological and behavioral modalities. In addition, there is little or no discussion of the contextual basis and functional significance of the current symptoms. 8. There is no documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention.

		Compliance: Partial. **Recommendations:** 1. Implement a format for psychiatric reassessments that addresses and corrects the deficiencies identified above. The format should be standardized for statewide use. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: a) Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b) Review of individual's progress in behavioral treatment; c) Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and d) Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. 3. Update the Department of Psychiatry Manual to include requirements regarding documentation of psychiatric reassessments. 4. Ensure that monitoring instruments are clearly aligned with all of the above expectations.
f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	1. Identified Target Symptoms: 79%; 2. Progress towards objectives in the WRP: 34%; 3. Identified risk behaviors: 77%; 4. Mental status examination: 91%; 5. Status of medical problems and treatment: 66%; and 6. Relevant laboratory data: 53%.

f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	The facility reports a variety of compliance rates based on different indicators. However, the indicators do not clearly address this requirement.
f.iii	Analyses of risks and benefits of chosen treatment interventions;	1. Rationale for current psychopharmacology plan: 46%; 2. Rationale for PRN medications/review of PRN/Stat medications: 13%; and 3. Benefits and risks of current psychopharmacological treatment: 14%.
f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	Risk status (is identified): 72%.
f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	1. Response to pharmacologic treatments: 75%. 2. Monitoring of side effects, including sedation: 41%.
f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	Rationale for PRN medications/review of PRN/Stat medications: 13%.
f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document	Response to non-pharmacological treatment: 62%.

	evidence of integration of treatments.	
g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Findings:** At this time, ASH does not have a transfer note policy or guideline for the psychiatric staff. On October 1, 2006, the Medical Director conducted an audit of ninety-nine charts randomly selected. The following outlines the compliance rates and corresponding indicators: 1. Psychiatric course in hospital reviewed: 6%; 2. Current medication trials included: 5%; 3. Current target symptoms present: 9%; 4. Current psychiatric risk assessment present: 7%; 5. Barriers to discharge present: 4%; and 6. Benefits to transfer present: 7%. This monitor reviewed charts of three individuals (WC, MAC and JWB) who required inter-unit transfers for psychiatric indications. In all three cases, the transfer assessments provided little if any information on the experience of the individuals on the unit of origin. Specifically, the assessments fail to include the reasons for the transfer, current target symptoms, psychiatric risk factors, a review of medication trials, the barriers to discharge and the anticipated benefits of the transfer. These assessments do not provide the receiving psychiatrist and WRP team with necessary information to ensure continuity of care and to minimize the risk for individuals. **Compliance:** Partial. **Recommendations:** 1. Update the Department of Psychiatry Manual to include requirements regarding timeliness, completeness and quality of inter-unit transfer assessments.

		2. Continue to monitor using current instrument and ensure that quality of clinical data is considered in the estimation of compliance. 3. Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.
2	**Psychological Assessments**	
		Methodology: Interviewed Ms. Susan Cahill, Staff Service Analyst. Interviewed Karen Sheppard, Ph.D., Acting Chief of Psychology Interviewed Diane Imrem, PsyD., Psychologist Interviewed Mat Hennessey, Ph.D. Psychologist. Interviewed Jeffery Teuber, Ph.D., Psychologist, PBS coordinator. Interviewed Jeanne Garcia, M.D. Acting Chief of Psychiatry, Reviewed 72 charts of individuals (GR, JO, NR, JR, SR, CR, JR, MN, TH, RW, VC, FC, DK, LB, SB, SH, DB, OA, GD, EM, RS, AH, SW, ES, PH, IH, JG, TL, JC, TG, RA, JP, CL, TR, LB, RC, JP, RC, JS, BR, JT, DA, BC, LB, ML, FL, TL, TC, SR, JS, TT, JR, JM, TM, AM, WW, TC, PD, WP, JR, ES, FM, OA,RC,JA,AG, RW, AN,BS,EM, JP, VS). Reviewed Psychology Manual (draft). Reviewed the Integrated Summary Assessment Form (Psychology section). Reviewed DMH WRP Manual. Reviewed DMH psychology monitoring form. Reviewed DSM-IV-TR Checklists. Reviewed database on psychologists verifying education, training, privileges, certification and licensure. Reviewed psychological and neuropsychological assessments. Reviewed Integrated Assessment-Psychology Section, Instructions Document. Reviewed list of Individuals under 1:1 monitoring and/or User of

		Restraints/Seclusion. DMH focused psychological assessment report format Reviewed ASH Assessment Center Tests Inventory and Manuals Reviewed ASH self-assessment. Reviewed Psychological Assessments Reviewed Structured Assessments Reviewed Functional Analysis Assessments.
a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Findings:** ASH Psychology Department is reviewing and revising most of the applicable manuals, protocols and procedures to ensure that these documents include all the elements of the EP, including policies and guidelines, privileging procedures, quality assessments, services and standard of practice and service delivery, and ethics. Interviews with psychologists, chart reviews, and observations showed significant differences among psychologists in their understanding of the required elements, such as integrated assessments, clinically indicated assessments, diagnostic assessments, development and implementation of interventions, and monitoring of efficacy. ASH's self-evaluation supports the monitor's findings. **Compliance:** Partial **Recommendations:** 1. Ensure that revised documents, where applicable, align across DMH hospitals. 2. Finalize and implement all applicable documents that codify the requirements of the EP. 3. Conduct competency-based training for all psychologists to the new clinical information included in the revised documents.

b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Findings:** ASH is deficient in this criterion. ASH does not have a proper system for tracking and monitoring this requirement. The individuals in ASH below 22 years of age had signed waivers from assessment and participation in Chapter 1 Special Education, or refused to be assessed. Many of the individuals who had signed waivers were enrolled in the Adult Continuing Education program in ASH. ASH does not have a means of tracking individuals who waived Special Education and may have enrolled in the Adult Continuing Education Program. **Compliance:** Partial. **Recommendations:** 1. Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days, unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team. 2. Get an accurate count of the individuals eligible to have their academic and cognitive assessments within 30 days. 3. Develop and implement monitoring and tracking instruments to assess this requirement. 4. Ensure that all psychologists understand this requirement. 5. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological	**Findings:** Credentialing of all Psychologists at ASH was reviewed through

	assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	interview of Dr. Karen Sheppard (Acting Chief of Psychology), Ms. Susan Cahill (Staff Service Analyst) and review of files. All psychologists working in ASH have the necessary education and coursework in assessment. Most Psychologists at ASH are certified, licensed, or credentialed. The Acting Chief of Psychology and the other senior psychologists provide individual and group supervision to the few unlicensed psychologists at the facility. It appears that the peer review processes are not completed in a timely manner due to shortage of staffing, and additional workload of the senior staff. Review of psychological assessments, neuropsychological assessments, PBS plans, and psychology Integrated Assessments reveals significant variations in the quality of these assessments. **Compliance:** Partial. **Recommendations:** 1. Ensure all psychology positions are filled. 2. Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training, and evaluating other psychology staff. 3. Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff. 4. Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with EP. 5. Conduct regular review of assessments to check for compliance and to provide corrective feedback to psychologists where necessary.
d	Each State hospital shall ensure that all psychological	**Compliance:**

	assessments, consistent with generally accepted professional standards of care, shall:	Partial.
d.i	expressly state the clinical question(s) for the assessment;	**Findings**: This monitor reviewed 21 psychological assessments (EM, RS, AH, SW, ES, PH, IH, JG, TL, JC, TG, RA, JP, CL, TR, LB, RC, JP, RC, JS and BR). Most of the assessments were generally adequate with varying levels of quality. All psychological assessments had a defined section to state the reason for referral/clinical question. Seventy-one percent of the assessments had specific statements on the reasons for referral/clinical question, whereas in 29% of the assessments, the statements under the reason for referral/clinical question section were verbose and vague. Most assessments failed to link summary and conclusions to specific interventions plans, or to recommend individuals for available therapy groups within ASH. Other psychological assessments, reviewed in the context of assessing WRPs, showed a great variability in content and quality. **Recommendations:** 1. Continue with the current structure of psychological assessments in which a section is dedicated to address reasons for referrals/clinical questions. 2. Ensure that the statements of the reasons for referral are concise and clear. 3. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. 4. Ensure that all psychological assessments meet at least generally acceptable professional standards.
d.ii	include findings specifically addressing the clinical	**Findings**:

	question(s), but not limited to diagnoses and treatment recommendations;	Eighty-five percent of the assessments reviewed met this criterion. Assessments on BR, JS, LB, CL, RA, and TG failed to clarify the reason for referral, recommend further assessments, or add information to assist therapeutic programming. **Recommendation:** Continue and improve on current practice.
d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Findings**: Eighty-five percent of the assessments reviewed provided recommendations/suggestions for psychosocial rehabilitation therapy and Mall services. The assessments on JS, BR, LB, CL, TG and RA did not provide any specific recommendations for therapeutic purposes. **Recommendation:** Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
d.iv	be based on current, accurate, and complete data;	**Findings**: ASH's self-assessment data showed that 33 of the 34 chart audits met this criterion. The 21 assessments reviewed by the monitor for this item generally met this criterion. **Recommendation:** Continue and improve on current practice.
d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	**Findings**: ASH's self-assessment data showed that only 9% of the audited assessments met this criterion. The assessments reviewed by the monitor failed to address the issue of Positive Behavior Support and specific behavior guidelines or behavioral plans.

		Recommendation: 1. Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. 2. Ensure that psychologists conducting assessments attend to this item.
d.vi	include the implications of the findings for interventions;	**Findings**: ASH's self-assessment showed 91% compliance to this item. The monitor's review found 72% compliance. **Recommendation:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.
d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Findings**: ASH's self-assessment showed only 55% compliance. The monitor reviewed 20 assessments (GR, JO, NR, JR, SR, CR, JR, MN, TH, RW, RC, VC, FC, DK, LB, SB, SH, DB, OA, and GD). Only 30% of the assessments complied with this item. **Recommendation:** Ensure that all psychological assessments meet this requirement.
d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Findings**: ASH's self-assessment showed 89% compliance. Assessments reviewed by the monitor showed that testing instruments used were appropriate to address the referral question. Most assessments utilized appropriate techniques, where necessary support from staff with American Sign Language ability for hearing-impaired individuals, and interpreters for non-English-speaking individuals has

		been secured. However, it is not possible to determine from the charts and assessments if the testing was in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. ASH self-assessment does not address this issue, and there is no indication that there is a system in place to track this aspect of the assessment. **Recommendations:** 1. Continue and improve upon current practice. 2. Abide by the American Psychological Association Ethical Standards and Guidelines for testing. 3. Ensure that American Psychological Association Ethical Standards and Guidelines for testing are followed.
e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	**Findings**: The monitor reviewed 20 assessments (GR, JO, NR, JR, SR, CR, JR, MN, TH, RW, RC, VC, FC, DK, LB, SB, SH, DB, OA, and GD,) to address this requirement. A number of these assessments (e.g., NR, JR, CR), were not conducted in a timely manner and there was no Integrated Psychological Assessment report in the chart for VC. The quality of the other assessments varied owing to elements that were not addressed or not addressed fully. **Compliance:** Partial **Recommendation:** Ensure that psychological tests are completed in a timely manner, as specified in the EP.

f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	**Compliance:** Partial.
f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	**Findings**: ASH evaluated this item through audit of Integrated Psychology Assessments (IPAs). The self-evaluation showed very poor compliance with this item. The compliance ranged between 2% for the month of July and 35% for the month of September. For all the IPAs between April and September 2006, eight (40%) of the 20 assessments reviewed by the monitor failed to meet this criterion. Two charts (VC and SB) did not have an Integrated Psychology Assessment. Information from Dr. Karen Sheppard, Acting Chief of Psychology, indicates that additional psychologists are needed to enable the timely completion of psychological assessments. **Recommendation:** 1. Ensure that Integrated Psychological Assessments are conducted in a timely manner as required. 2. Ensure adequate number of psychologists to provide timely psychological assessments of individuals.
f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Findings**: ASH self-evaluation showed that five (15%) of the 34 assessments reviewed failed to comply with this criterion. Almost half (45%) of the assessments reviewed by the monitor failed to address the nature of the individual's impairments to inform the psychiatric diagnosis.

		Recommendation: Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.
f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Findings**: ASH's self-assessment used integrated psychological assessments to evaluate this item showed a high compliance rate ranging from 89% to 95% on the monthly audits of assessments conducted between April and September, 2006. Reviews conducted by the monitor showed that very few assessments fulfilled this criterion. For example, only 4 of the 22 (18%) assessments with 'no diagnosis', 'Not otherwise specified', and 'deferred' on Axis' I and II, sought further clarification or completed further assessments recommended. Failure to seek diagnostic clarity or failure to follow through with recommended assessments limits available data on the individual's psychological functioning that would inform the WRP process. The discrepancy between ASH's self-assessment and the monitor's findings is a function of the extent of elements considered for this item. ASH used a more narrow focus to address this requirement. **Recommendation:** 1. Ensure that all elements that would affect complete understanding of an Individual's psychological functioning are considered when monitoring this item. 2. Ensure accurate evaluation of psychological functioning that informs WRP teams of the individual's rehabilitation service needs
f.ii	if behavioral interventions are indicated, a structural	**Findings**:

	and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	ASH is very deficient in this item. Review of facility records showed that there are 335 individuals (as of April 1, 2006) in ASH with significant behavioral issues (these behavioral domains include self-management of psychiatric symptoms, self-management of assaultive behaviors, control of self-injurious/suicidal behaviors, self-care, and control of deviant sexual impulses and behaviors). Other data reveal that there are 722 individuals documented to have severe behavioral issues necessitating 1:1 monitoring and/or use of Restraint/Seclusion. In either case, the number of referrals to the PBS team is minimal (37). The lack of referrals to the PBS team can be due to factors including poor understanding of when to make a referral or lack of confidence in receiving a timely response from the PBS team. Furthermore, a number of individuals (30 at the time of this monitoring) have been referred to the Patient Care Monitoring Committee (PCMC), instead of to the PBS team and subsequently to the BCC should the PBS intervention fail to result in progress. ASH's self-evaluation data showed there were very few behavioral interventions. Three of the 16 referrals reviewed did not have a functional assessment completed, and there were no structural assessments. One program had received 21 referrals for which the PBS team has yet to complete the assessments and/or implement interventions. The monitor's chart review of individuals with behavioral issues confirmed ASH self-evaluation. There are written PBS plans that are yet to be implemented. PBS team members reported that they are hampered by lack of time and shortage of staff to conduct the necessary training of Level of Care staff to implement the PBS plans. ASH has one-half of one PBS team. There are very few behavioral guidelines and structured and functional

		assessments on individuals with learned maladaptive behaviors. **Recommendation:** 1. Ensure that Level of Care staff is familiar with referral criteria to the PBS team when individuals have significant learned maladaptive behaviors that were not amenable to behavioral guidelines. 2. Ensure that PBS referrals get timely attention to assist Level of Care staff to manage individuals with significant learned maladaptive behaviors. 3. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. 4. Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC.
f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Findings**: ASH is very deficient on this item. A total of 24 integrated assessments of individuals carrying a 'No Diagnosis' or 'deferred' on Axis II were reviewed. Seventeen (71%) of the reports failed to recommend additional assessments to clarify diagnoses, or follow through with additional assessments when one was recommended. **Recommendations:** 1. Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient, and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. 2. Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e., that "no

		diagnosis" is backed up by clinical data, especially in individuals with forensic issues. 3. Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent.
g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Findings:** ASH is deficient on this item. According to Dr. Karen Sheppard, Acting Chief of Psychology, ASH uses a screening tool (B-VAT) and other linguistic tests to assess language competency of individuals whose primary language may not be English. ASH's self-assessment showed that three focused assessments did not indicate that the individual's primary language was other than English. ASH's self-assessment also indicated that the Spanish-speaking SVP treatment groups are not well served due to the lack of a second therapist and a translated treatment protocol. A review of ten charts (OA, RC, JA, AG, RW, AN, BS, EM, JP and VS) of individuals whose primary or preferred language is not English showed that seven (70%) of their assessments were conducted in their preferred language or deemed that their English was functional enough for a valid assessment in English. As for the remaining three (30%), it was not clear if RC's English was adequate for a valid assessment; JA, Spanish speaking, was assessed in English even though the WRP indicated that JA had difficulty processing information. **Compliance:** Partial. **Recommendations:** 1. Ensure that examiners consider cultural aspects when choosing

		assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.
3	**Nursing Assessments**	
		Methodology: Interviewed Carol Constien, Coordinator of Nursing Services. Interviewed Al Joachim, Acting Assistant Coordinator of Nursing Services/Health Services Specialist (HSS). Interviewed Arlene Gasch, HSS. Interviewed Donna Hunt, HSS. Interviewed Vickie Vinke, HSS Interviewed Sharon McCartney, HSS Reviewed Medication Administration Monitoring data. Reviewed Statewide Medication Administration Monitoring Form raw data. Reviewed DMH Statewide 24-Hour Noc Shift Audit Monitoring Form. Reviewed DMH Nursing Services PRN/Stat Medications Monitoring Form. Reviewed the PRN Pain Management Flow Sheet Form. Reviewed DMH Nursing Services Nursing Monitoring: Nursing Interventions Tool and Instructions. Reviewed DMH WRP Conference Process Observation Results By Response data. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For That Individual. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For That Individual Monitoring Form. Reviewed DMH Nursing Services: Shift Change Monitoring Form and

		Instructions. Reviewed DMH WRPC CET Team Attendance and Nursing Participation Monitoring Form and Instructions. Reviewed DMH Monitoring Form for Bed-Bound Individuals. Reviewed MOSES Monitoring Tool (draft). Reviewed Section III Integrated Therapeutic and Rehabilitation Services Planning Tool (draft). Attended shift report for Unit I.
a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
a.i	a description of presenting conditions;	**Findings**: The data provided by ASH did not address whether nursing procedures/protocols included the elements of this section. A grid of several nursing policies and procedures was presented in the data, but did not specifically address each of the elements from this requirement. The facility assessed its compliance with the requirements in D.3.a.i through a.ix. The compliance rate for this item is 96%. The rates for D.3.a.ii through a.ix are identified for each section below. From my review, Admission Nursing Assessments did not adequately address the description of presenting conditions, activities of daily living, and currently prescribed medications. This finding differs with ASH's findings. **Recommendations:** 1. Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement. 2. Ensure that nursing staff is competent in the protocols

		addressing this requirement. 3. Ensure that nursing staff adequately tracks, documents and monitors this requirement.
a.ii	current prescribed medications;	64%.
a.iii	vital signs;	95%.
a.iv	allergies;	94%
a.v	pain;	94%.
a.vi	use of assistive devices;	97%.
a.vii	activities of daily living;	100%.
a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	96%.
a.ix	conditions needing immediate nursing interventions.	86%.
b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Findings:** ASH has been using the Johnson Behavioral System Model (JBSM) for assessing acuity levels on the units related to staffing needs. However, the use of a medical nursing model does not lend to the integration of nursing practice to the Wellness and Recovery Planning system. The model currently does not lend to identifying staffing needs for Mall activities and groups. The current deficits in the nursing assessments, progress notes, and nursing interventions are in conflict with the process of the Wellness and Recovery Model. **Compliance:** Partial. **Recommendations:** 1. Revise policies and procedures to include WRP language. 2. Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles.

		3. Align current training of nurses with the WRP system.
c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Findings:** ASH has not developed a system for monitors of the nursing assessment to ensure that concurrent monitoring of the same assessment is done in order to compare rater reliability. ASH did not provide data addressing this requirement. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a monitoring instrument and a tracking system to adequately address this requirement. 2. Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.
d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.
d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Findings**: ASH reported 99.6% compliance with this requirement based on data collected from May to September 2006. From my review of ten initial nursing assessments, all were completed within the required timeframe. **Recommendation:** Continue to monitor this requirement.
d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and	**Findings**: ASH reported that tools developed to monitor for timeliness of

	rehabilitation service plan within seven days of admission; and	assessment (within seven days) do not address the integration of the assessment into the WRP. **Recommendation:** Develop and implement a monitoring instrument and tracking system to include the elements of this requirement.
d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Findings**: There is no system in place that monitors and tracks this requirement. **Recommendations:** Develop and implement a monitoring system to address the elements of this requirement.
4	**Rehabilitation Therapy Assessments**	
		Methodology: Interviewed LaDonna DeCou, Chief of Rehabilitation Services, Program Consultant. Interviewed Mary Jo Bonnevile-Waugh, RN Supervisor for Central Medical Services (Stayed for a portion of the interview) Interviewed Doug Shelton, M.D., Chief Physician and Surgeon, Director of Central Medical Services (Stayed for a portion of the interview). Interviewed Elizabeth Price, Speech Language Pathologist (SLP). Reviewed Rehabilitation Service Staff Roster. Reviewed California's Title 22 State Regulation. . Reviewed ASH Policy for Rehabilitation Therapy Assessment (draft). Reviewed ASH Rehabilitation Services Manual. Reviewed Integrated Rehabilitation Therapy Assessment tool (draft). Reviewed Integrated Rehabilitation Therapy Assessment audit. Reviewed Individual Training Report for past three years for Rehabilitation staff. Reviewed ASH Patient Education Tools for Crutch Fitting and

		Wheelchairs. Reviewed Rehabilitation Therapy Documentation Audit tool and raw data. Reviewed charts of ten individuals (LS, HS, DR, RA, CB, RM, RC, FH, JN and ED). Reviewed list of individuals that have adaptive equipment. Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia and aspiration. Reviewed list of individuals with hearing aids. Observed individuals in wheelchairs on Unit I and in facility hallways. Reviewed PT caseloads. Reviewed Speech Therapy Referral Tracking Sheets. Reviewed PT and Speech assessments. Received shift report and did walking rounds with Supervising RN, Pat O'Rourke on Unit I.
a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Findings:** Review of the Rehabilitation Therapy assessments for the above-listed individuals did not include components to trigger an Occupational Therapy (OT), Physical Therapy (PT) and/or Speech Therapy referral when appropriate. In addition, ASH does not provide OT services and PT and Speech Therapy are not included under Rehabilitation Services. These therapy specialties are separated under medical and do not have integration with the Rehabilitation Department. In addition, there is no OT Manual, and the Speech Pathology Manual and the Physical Therapy Manual need to be reviewed for consistency with psychiatric rehabilitation and recovery model of service delivery. The Rehab Chiefs have revised the Comprehensive Rehabilitation Assessment; however, there was no input provided from OT, PT and Speech Therapy.

		Compliance: Partial. **Recommendations:** 1. Obtain OT services. 2. Integrate OT, PT and Speech Therapy into the Rehabilitation Therapy Services. 3. Revise the Comprehensive Rehabilitation Assessment with input from OT, PT, and Speech Therapy to include functional abilities that would indicate a need for OT, PT and/or Speech Therapy. 4. Revise, update, and implement policies, procedures, operations manuals and ADs to address this requirement. 5. Develop and implement a monitoring system to address the elements of this requirement. 6. Develop, review and revise OT, PT, and Speech Pathology Manuals to include Wellness and Recovery language.
b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Findings:** The current Rehabilitation Assessment tool does not provide an accurate and comprehensive assessment as to the individual's functional abilities, functional status, or life goals, strengths, and motivation for engaging in wellness activities related to these areas. As mentioned above, the Rehabilitation Assessment does not include indicators related to OT, PT, and Speech Therapy to trigger a referral to these therapies if needed. Referrals to these therapies are obtained only through a physician's order and usually based only on an acute event, such as a fracture. There is no system in place to proactively identify individuals with OT, PT, and/or Speech Therapy needs. In addition, the assessments conducted by PT, and Speech

		Therapy are not integrated into ASH's Rehabilitation Assessments or the individual WRPs. Also, from my observations of individuals on Unit I as well as from review of the rehabilitation assessments, there are several individuals who have significant unmet rehabilitation needs in the areas of OT, PT, and Speech Therapy regarding dysphagia, positioning, mobility and wheelchairs. The needs include interventions that are sufficient to promote appropriate and functional body alignment. In addition, there is no system in place to monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. **Recommendations:** 1. Revise appropriate policies, procedures and manuals to be aligned with this requirement. 2. Develop and implement a system for monitoring and tracking the elements of this requirement. 3. Include indicators related to OT and PT in the Rehabilitation Assessments to trigger referrals to these therapy specialties. 4. Identify, assess, develop and implement proactive interventions for individuals with OT, PT and/or Speech Therapy needs. 5. Integrate OT, PT and Speech Therapy assessments and interventions into the individual WRPs. 6. Assess and develop 24-hour, proactive interventions for individuals at risk for choking and aspiration. 7. Provide ongoing competency-based training to all team members regarding dysphagia. 8. Assess the mobility needs and provide individual wheelchairs that promote appropriate body alignment for individuals who depend on the use of wheelchairs for the majority of their

		mobility. 9. Streamline the process of obtaining adaptive equipment. 10. Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. 11. Develop a monitoring system to ensure that individuals have access to their adaptive equipment, that it is in proper working condition, and that it is being used appropriately. 12. Re-evaluate the adaptive equipment at least annually or in response to individuals' status changes to ensure that it is meeting the individuals' needs. 13. Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. 14. Provide augmentative/adaptive communication devices for individuals with communications issues.
b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	As above.
b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	As above.
c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Findings:** ASH reported 100% compliance with pre-hiring credentialing for the last 23 new hires and four reinstatements to State service and 86% compliance that Rehabilitation Therapists received initial training on Integrated Rehabilitation Therapy Assessment from February 2, 2006 to present. However, OT, PT and Speech Therapy were not included in the data for this requirement. In addition, there is no monitoring instrument or system in place to ensure that that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are

		verifiably competent in performing the assessments for which they are responsible. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a system to ensure that OT, PT and Speech therapists are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a monitoring system to adequately address the elements of this requirement.
d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Findings:** ASH reported that 518 individuals do not have an integrated Rehabilitation Assessment completed. A plan to complete these assessments will be developed and initiated after the Rehabilitation Assessment is revised. As mentioned above, the current Rehabilitation Assessment tool does not provide an accurate and comprehensive assessment. **Compliance:** Partial. **Recommendations:** 1. Same as recommendations in section D.4.a. 2. Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to ASH are reviewed by qualified clinicians and, as indicated, revised to meet the requirements of Title 22.

5	**Nutrition Assessments**	
	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed Erin Dengate, Assistant Director of Dietetics.. Reviewed Nutrition Care Monitoring Tool (NCMT). Reviewed Nutrition Care Process (NCP). Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed Nutrition Status Type (NST) acuity and indicators form. Reviewed list of residents with dysphagia. Reviewed AD Wellness and Recovery Planning. Reviewed AD Treatment Planning. Reviewed Nutrition Services P & P Nutrition Referral Process. Reviewed NCM Enteral Feeding. Reviewed Nursing P & P Care of the Choking Person. Reviewed Nursing P & P Tube Feeding. Reviewed AD Therapeutic Diets and Nourishments. Reviewed Enteral Nutrition Support policy. Reviewed dietary data provided by ASH.
a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Findings:** ASH reported 0% compliance with this requirement. This was based on a total of three individuals who met this criterion. In addition, there were issues identified regarding the quality of these assessments, which included most of the items (2-15) listed on the NCMT. At the time of this review, there were no additional individuals that met this criterion to review based on information provided by the facility. My review of the same individuals, DH, RA, and AW, yielded comparable results. **Compliance:** Partial.

		Recommendations: 1. Develop and implement a high-risk referral monitoring and tracking system to identify individuals who meet this criterion to ensure that they receive adequate and timely nutrition assessments. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	**Findings:** ASH reported that no individuals currently met this criterion. **Compliance:** Not applicable. **Recommendations:** Continue to monitor this requirement.
c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Findings:** ASH does not have a skilled nursing facility unit. **Compliance:** Not applicable. **Recommendations:** Not applicable.
d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a	**Findings:** ASH reported 81% compliance with this requirement. This compliance percentage was based on a total of 21 individuals who met this criterion from May to June 2006. From this monitor's review of five charts, I found three (JJ, VT and

	comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	RN) in compliance and two (JD and FB) not in compliance with this requirement. In addition, I noted issues with the quality of the Admission Assessments. **Compliance:** Partial. **Recommendations:** 1. Ensure that new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24 hours, and MAOI, as clinically indicated) are provided a comprehensive Admission Nutrition Assessment. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Findings:** ASH reported no data for this requirement. **Compliance:** Not applicable. **Recommendation:** Ensure that new admissions with therapeutic diet orders for medical reasons receive a comprehensive Admission Nutrition Assessment within seven days of admission.
f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of	**Findings:** ASH reported 100% compliance with this requirement based on a review of one individual who met the requirement. ASH also reported there were deficiencies in the quality of this Nutrition Assessment.

	admission.	**Compliance:** Partial. **Recommendations:** 1. Continue to monitor this requirement to ensure compliance. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Findings:** ASH reported 95% compliance with this requirement. A total of 19 charts were reviewed. This monitor found three out of three Admission Nutrition Assessments were in compliance with this requirement (AF, DO and JS). ASH reported a total of 75% compliance with quality of these Admission Assessments. Similarly, this reviewer found issues regarding the quality of the Admission Nutrition Assessments **Compliance:** Partial. **Recommendations:** 1. Continue to monitor Admission Nutrition Assessments to ensure that they are completed in a timely manner. 2. Ensure staff competency regarding deficiencies and appropriate procedures for Admission Nutrition Assessments.
h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered	**Findings:** ASH reported that the new Nutrition Status Type (NST) criteria were implemented July 1, 2006. Nutrition Assessments (April to September

	dietitian.	2006) were audited using the new criteria. The overall compliance rate was 77%. A review of the compliance rates for each month (April to September 2006) indicates that compliance has improved since the NST criteria were implemented. **Compliance:** Partial. **Recommendations:** Continue to monitor this requirement.
i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Findings:** The current NCMT does not address all the elements included in this requirement. **Compliance:** Partial. **Recommendations:** Incorporate all elements of this requirement into the NCMT.
j.i	Individuals will be reassessed when there is a significant change in condition.	**Findings:** ASH reported 81% compliance with the requirement regarding reassessments when there is significant change in the individual's condition. The compliance rate with the quality of these reassessments was 72%. The facility reported 82% compliance with the reassessments upon non-administrative transfer to medical/surgical unit and 72% compliance regarding quality of these reassessments. **Compliance:** Partial.

		Recommendations: 1. Continue to monitor compliance with this requirement. 2. Develop and implement monitoring system to ensure that these individuals are adequately reassessed in a timely manner. 3. Provide training on components of an adequate assessment for changes in conditions.
j.ii	Every individual will be assessed annually.	**Findings:** ASH reported 96% compliance with completion of annual nutritional assessments and 69% compliance regarding quality of these assessments. A total of 26 annual nutritional assessments were reviewed. From this monitor's review of 11 charts, all were found to have an annual nutritional assessment. A lower compliance rate was found when the quality of the assessments was considered, which corroborates the facility's findings. **Compliance:** Partial. **Recommendations:** 1. Continue monitoring and tracking this requirement. 2. Ensure staff competency regarding deficiencies and appropriate procedures for annual Nutrition Assessments.
6	**Social History Assessments**	
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed Nancy Green, LCSW, Chief Department of Social Work Interviewed David Curtiss, LCSW, Clinical Social Work; Chairperson Department of Social Work. Reviewed 21 charts (NG, KM, GH, QW, JS, MD, DR, RC, JW, GW, LC, RC, TW, RL, RG, AM, DP, AD, XF, CD and DZ). Reviewed 30 Day Psychosocial Assessment, Instructional Manual.

		Reviewed 30 Day Psychosocial Assessment Monitoring Form. Reviewed Social Work Integrated 5 day Monitoring Form. Reviewed AD #410 Reviewed AD #414. Observed WRP team meetings.
a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Findings:** A high percentage of the Social History Assessments were not conducted in a timely manner. The Social Work monitoring tool lacks indicators to evaluate quality and accuracy information. ASH's self-assessment showed a timeliness range between 41% and 100% on the five-day assessments and a range between 0% and 100% on the 30-day assessments. There are no annual assessments. Twenty percent of the five-day assessments (4 out of 20), and 25% of the 30-day assessments (5 out of 20) reviewed by the monitor were out of timeline. **Compliance:** Partial. **Recommendations:** 1. Implement the five-day, 30-day, and annual social history evaluations. 2. Include quality and accuracy indicators in the Social Work monitoring instruments. 3. Develop, finalize and implement statewide annual social history evaluations. 4. Align monitoring tools with the Evaluation Plan. 5. Ensure that all social history assessments are conduct in a timely manner.

b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Findings:** ASH's self-assessment showed that this item is not attended to by staff when conducting social history assessments. Factual inconsistencies affect all aspects of the individual's services. As such, they should be carefully reviewed and resolved at the earliest possible time. This monitor observed a WRP conference in which MN pointed out numerous discrepancies on his demographic information to his WRP team. A few of the factual discrepancies pointed out by MN included number of siblings, birthplace, names of parents, and previous legal problems amongst others. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. 3. Ensure that Social Work staff track and monitor this requirement.
c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Findings:** Staff needs to ensure that the five-day assessments are timely to fulfill this requirement. A significant percentage (20%) of the five-day assessments and 25% of the 30-day assessments were not timely for them to be included in the individuals' seven- and 30-day WRP team conferences, respectively.

		Compliance: Partial. **Recommendations:** 1. Ensure all SW integrated assessments are completed and available to the WRP team before the seven-day WRP conference. 2. Ensure that all 30-day social histories are completed and available to the WRP team members by the 30th day of admission.
d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Findings:** Among the 20 social histories reviewed, information in four (20%) of the assessments failed to include relevant information in a timely manner to fully inform the individual's interdisciplinary team on the individual's social factors and educational status. For example, AD had no educational and social history on the five-day assessment and no educational, psychosocial, discharge plan or community integration on the 30-day assessment. DP had no social history on the five-day assessment and no discharge planning or community integration on the 30-day assessment. MD's assessment date was before the admission date. GH did not have a social history on the five-day or the 30-day evaluation. **Compliance:** Partial. **Recommendation:** Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRP team.

7	Court Assessments		
		Methodology: Interviewed William Knowlton, Ph.D., Director, Forensic Services. Interviewed Marc Scherrer, Ph.D., Senior Psychologist. Reviewed charts of six individuals admitted under PC 1026 (THR, DWH, GAG, WTM, MAC and MPR). Reviewed charts of five individuals admitted under PC 1370 (NPM, DRR, SSR, JFS and RM). Reviewed Self-Monitoring Tool Form PC 1026/1370 Court Assessments. Reviewed Self-Monitoring Summary Data (April to August 2006).	
a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Partial.	
a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Findings**: ASH does not have an AD/policy/procedure that addresses the requirements of this section. DMH Special Orders #302 and 334 make reference to a PC 1026 court assessment policy but do not address an interdisciplinary approach to the development of court submissions for these individuals. The facility has developed and implemented a self-monitoring tool to assess its compliance with all provisions in section D.7.a. Using ASH Self-Monitoring Tool for PC 1026/1370 Court Assessments, the facility reviewed all PC 1026 court submissions from April 1, 2006 through August 31, 2006 (n=2). Based on this review, the facility found 100% compliance with this item.	

		This monitor reviewed the charts of six individuals adjudicated NGRI. In reviewing item 7.a.i, this monitor found non-compliance in five charts (THR, DWH, WTM, MAC and MPR) and compliance in only one (GAG). **Recommendation:** 1. Ensure that the facility's AD codifies all plan requirements regarding the content of 1026 court submissions. 2. Ensure that the FRP reviews all PC 1026 reports and provide feedback to the WRP teams to achieve compliance. 3. Ensure adequate monitoring sample in the self-assessment data.
a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Findings**: ASH found that 100% of the evaluations reflected acts of verbal/physical aggression and property destruction for the past year and that 100% of the past acts of aggression and dangerous criminal behavior were noted. This monitor's reviews indicate non-compliance in four charts (THR, WTM, MAC and WPR) and partial compliance in two (DWH and GAG). **Recommendation:** Same as above.
a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Findings:** The facility's monitoring data indicate the following: 1. Fifty% of the evaluations noted the individual's understanding regarding potential for dangerous criminal behavior; 2. None of the evaluations noted the individual's understanding regarding precursors for dangerous criminal behavior; and 3. None of the evaluation noted the individuals understanding regarding precursors associated with the instant offense.

		This monitor found non-compliance in all charts reviewed. **Recommendation:** Same as above.
a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Findings**: The facility's monitoring data indicate the following: 1. Fifty percent of the evaluations noted the individual's acceptance of their mental illness. 2. None of the evaluations noted the individual's understanding of the need for treatment. 3. None of the evaluations noted the individual's understanding of the need to adhere to treatment. Reviews by this monitor demonstrated non-compliance in all charts reviewed. **Recommendation:** Same as above.
a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	**Findings**: The facility found 0% compliance with this requirement. This monitor's review corroborates this finding. **Recommendation:** Same as above.
a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Findings**: The facility found that 50% of the evaluations noted the individual's willingness to understand substance abuse issues and that 0% of the evaluations noted the individual's willingness to develop an effective substance abuse relapse prevention plan.

		This monitor found non-compliance in all reviews when the requirement was applicable. **Recommendation:** Same as above.
a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Findings**: The facility found 50% compliance with this requirement. This monitor found non-compliance in the only chart (MAC) that met the criteria for this requirement. **Recommendation:** Same as above.
a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Findings**: The facility's data indicate non-compliance with the element regarding cultural marginalization and 50% compliance with all the other elements cited in this requirement. This monitor found non-compliance in all six charts reviewed. **Recommendation:** Same as above.
a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Findings**: The following is an outline of the facility's findings: 1. 50% of the evaluations noted the relevant medical issues. 2. None of evaluations noted self-harm issues. 3. None of the evaluations noted the risk for self-harm. 4. All the evaluations noted the risk of harm to others.

		This monitor found non-compliance with the intent of this requirement in all the charts reviewed. **Recommendation:** Same as above.
b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	**Compliance:** Partial.
b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Findings**: The facility reviewed one third of all PC 1370 reports from April to August 2006 (N=19) to assess compliance with provisions of D.7.b. The monitoring data indicate that 80% of the evaluations described the individual's clinical condition which caused him to be found incompetent to stand trial. This monitor reviewed the charts of five individuals admitted under PC 1370 (NPM, DRR, SSR, JFS and RM). In reviewing item D.7.b.i, the monitor found partial compliance in three charts (SSR, JFS and RM) and non-compliance in two (NPM and DRR).

		Recommendation: Same as D.7.a.i (as applicable to PC 1370).
b.ii	clinical description of the individual at the time of admission to the hospital;	**Findings**: The facility's data indicate that 94% of the evaluations noted a clinical description of the person at the time of ASH admission. This monitor found compliance in three charts (SSR, JFS and RM) and non-compliance in two (NPM and DRR). **Recommendation:** Same as above.
b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	**Findings**: The facility's data indicate the following: 1. 84% of the evaluations noted a description of the person's response to treatment. 2. All the evaluations noted a description of the person's current MSP. 3. 84% of the evaluations noted the reasoning provided to support the forensic recommendations. Chart reviews by this monitor indicate that the court submissions in most charts (NPM, SSR, JFS and RM) are not in compliance. There is partial compliance in one chart of DRR. **Recommendation:** Same as above.
b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Findings**: The facility's reviews show 84% compliance with this requirement.

		This monitor found non-compliance in all five charts reviewed. **Recommendation:** Same as above.
c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	**Findings:** ASH does not have a functional FRP. **Compliance:** Non-compliance. **Recommendations:** 1. Develop and implement a procedure that specifies membership, duties and responsibilities of a FRP. 2. Ensure that the panel performs the primary function of reviewing all court reports for individuals admitted under penal codes 1026 and 1370. The panel must provide feedback to WRP teams to ensure compliance with all above requirements.
c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Findings:** As above. **Compliance:** Non-compliance. **Recommendation:** As above.

E	Discharge Planning and Community Integration	
		Summary of Progress: 1. ASH has correctly recognized that discharge planning focus begins from the individual's first day of admission. 2. Social workers are provided training in the discharge process. 3. ASH has adopted WRP as an essential tool towards addressing the individual's rehabilitation needs and preparation of the individual for discharge and community integration. 4. ASH is in the process of improving on various forms and tools for tracking and monitoring of the requirements for this section.
	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** Interviewed Nancy Green, LCSW, Chief, Department of Social Work. Interviewed David Curtiss, LCSW, Clinical Social Worker; Chairperson Department of Social Work. Reviewed WRP: audit form. Reviewed ASH self-assessment data. Reviewed 22 charts (EO, SC, TR, EJ, KR, BS, DF, AM, NZ, AO, DW, TH, RM, DZ, AF, GM, ES, SS, JA, FC, PJ and MP). Observed WRP team meetings.
1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Findings:** Data from the WRP Chart Audits showed severe deficiency on this objective. None of the charts reviewed by the monitor met all required elements for any one individual. The main deficient elements in the charts reviewed included: EO: discharge placement; SC: criteria not written in observable or measurable terms; TR: no linkage between discharge criteria and treatment plan; EJ: discharge criteria not specific; KR: present status does not address discharge criteria;

		BS: discharge not addressed; AM: no treatment plan; TH: present status not specific; RM: objective unclear; DZ: multiple objectives lumped together; GM: present status not updated; and FC: did not identify who will do what and when. ASH's self-assessment also showed a similar trend with less than 14% of the audits meeting the required elements. **Compliance:** Partial. **Recommendations:** 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRP team process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR Mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. 3. Social workers must review discharge status with the WRP team and the individual at all scheduled WRP conferences involving the individual. 4. Ensure that staff conducting assessments are aware of, trained in, and track this requirement
1a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Findings:** ASH WRP Chart Audit data showed that this element was absent more than 71% of the time. As identified in #1 above, the charts reviewed by the monitor failed to meet one or more criteria.

		Observation of WRP team conferences showed varying levels of discussion of the individual's strengths, preferences and interests. Personal life goals are not integrated into the individual's treatment planning as it relates to the individual's psychosocial rehabilitation services and discharge criteria. ASH self-evaluation showed that this requirement was not met. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to the focus/foci of hospitalization, with associated objectives and interventions.
1b	the individual's level of psychosocial functioning;	**Findings:** Only one of the five WRP teams observed by the monitor discussed and/or adjusted GAF scores during the WRP meeting, and included the individual in finalizing the score. ASH self-evaluation data was not specific to this requirement. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case

		formulation. 3. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
1c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Findings:** There is a general lack of attention given to this item. None of the WRP conferences observed by this monitor identified barriers to transition to a more integrated environment and/or discussed this amongst the interdisciplinary team members or with the individual on what was expected of him to meet this objective. ASH's self-assessment failed to assess this requirement. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRP conferences. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. 3. Report to the WRP team, on a monthly basis, the individual's progress in overcoming the barriers to discharge.
1d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Findings:** ASH is very deficient in this requirement. In many cases, Social Work notes contain elements of this item. However, the information is not utilized in WRP meetings to develop appropriate interventions and guide the individual to appropriate group and individual therapies or Mall groups.

		Attention is not given to the individual's required skills that will enhance his placement in the least restrictive environment. Often, objectives and present status statements are written in the negative, i.e., what the individual should not be doing rather than what skills the individual should acquire/perform. The individual's skill changes/ improvements were not discussed or updated in the WRP team conferences observed by this monitor. ASH self-assessment failed to assess this requirement. **Compliance:** Non-compliance. **Recommendations:** 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Include these skills and supports in the individual's WRP subsequent WRP conferences. 3. Ensure that WRP team members focus on these requirements and update the individual's WRP plans as necessary.
2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Findings:** All of the WRP conferences observed by this monitor discussed this item at various points during the conference. However, in most cases the interdisciplinary team failed to review the individual's level of understanding and what the individual should achieve/report at the next WRP team conference. In some instances, digression among team members to previous or additional information unrelated to the topic of discharge planning/progress made it difficult for the individual to fully follow the information/discussion. It may be beneficial to both the team and the individual if the discharge issues are reviewed at the end of the conference with the individual being requested to explain/repeat the requirements.

		ASH's self-assessment showed that this requirement was missing 97% of the time from the 39 WRP conferences evaluated by trained observers. **Compliance:** Partial. **Recommendations:** 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRP conference.
3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Findings**: ASH did not assess this item during the self-assessment. ASH is deficient on this item. As discussed in E.1., all the charts reviewed by the monitor were missing one or more of the required elements. The linkage between the discharge criteria, group/individual therapy, and Mall group assignments was absent. **Recommendation:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.

3a	measurable interventions regarding these discharge considerations;	**Findings:** ASH failed to assess this requirement during the self-assessment. Interventions are not operationalized in measurable and or observable terms. Target behaviors for interventions are often written in the negative, i.e., what the individual will not do instead of what the individual will do. **Compliance:** Non-compliance. **Recommendation:** Write all interventions, including those dealing with discharge criteria, in behavioral and/or measurable terms as outlined in the DMH WRP Manual.
3b	the staff responsible for implement the interventions; and	**Findings**: ASH did not assess this item during the self-assessment. Most of the charts reviewed by the monitor included names of physicians and psychologists, but names of other disciplines were generally missing (e.g., FC). **Recommendations:** 1. Ensure that for each intervention, responsible staff members are clearly stated in the Individual's WRP. 2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.
3c	The time frames for completion of the interventions.	**Findings:** ASH did not assess this item during self-assessment. A number of charts reviewed showed a range of deficiencies including absence of dates and arbitrary choice of dates without consideration

		of the nature of the behavior (e.g., intensity, frequency, previous treatment history). **Compliance:** Partial. **Recommendations:** 1. For each intervention in the Mall or for individual therapy, clearly state the time frame for the next scheduled review. This review should be the same as the individual's next scheduled WRP conference. 2. Ensure that target dates for completion of intervention take into account the difficulty of the intervention and previous interventions, if any.
4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Partial.
4a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Findings**: ASH did not assess this item during self-assessment. Information from staff and individuals, and observation of WRP team conferences, suggested that in a number of cases discharge was not met in a timely fashion. For example, JM reported that change in medication (for reasons not explained to him) before his discharge caused his behavior to deteriorate, thus delaying his discharge. In another case, MN had met all his discharge goals and was ready for discharge, but a team member decided that MN was not ready. The decision was based on a "feeling" and not by any supportive data. The team member convinced the rest to go along and the team decided to write a new criteria.

		It will be helpful if WRP teams take the time to review discharge criteria and revise the criteria, when appropriate, using objective data long before the individual achieves all his discharge criteria. **Recommendations:** 1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made. 2. Identify and resolve system factors that act as barriers to timely discharge. 3. Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. 4. Ensure that attention is given to reasons for admission, previous assessment, and possible discharge settings are taken into account when setting discharge criteria. 5. Use objective data for all discharge criteria and planning, and not on personal bias or "feelings" of what the individual may do when they get out.
4b	Individuals receive adequate assistance in transitioning to the new setting.	**Findings**: By policy, the hospital's responsibilities end when an individual is discharged from the facility. There is no clear way of identifying from the current documentation system if an individual was provided with adequate assistance when transitioning to a new setting. Information from Ms. Nancy Green, Chief, Department of Social Work, indicated that Social Work staff communicates with county case workers to provide necessary information to aid in the individual's adjustment to the new settings. **Recommendations:** 1. Develop and implement a monitoring and tracking system to address the key elements of this requirement. 2. Ensure and document specific assistance provided to the individual and/or appropriate others when the Individual is

		transitioned to a new setting. 3. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. Where appropriate and possible, provide these supports and assistance to the individual.
5	For all children and adolescents it serves, each State hospital shall:	**Compliance:** Not applicable, ASH does not serve children and adolescents.
5a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	**Findings**: Not applicable.
5b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	**Findings**: Not applicable.

F	Specific Therapeutic and Rehabilitation Services	
		Summary of Progress: 1. ASH has a medication management system that includes reviews by a Pharmacy and Therapeutics (P&T) Committee and a Medication Review Committee (MRC). 2. ASH has a specialized clinic that coordinates the care of individuals receiving clozapine. 3. ASH collects data regarding adverse drug reactions (ADRs). 4. ASH has a tracking system to aggregate ADR-related data. 5. ASH collects data regarding medication variances (errors). The current system, known as medication system failures (MSF), contains several important categories of actual variances. 6. ASH has data regarding facility-wide trends in some actual MSFs and some remedial steps taken in response to this analysis. 7. ASH has initiated a Drug Utilization Evaluation (DUE) system. 8. ASH has provides adequate medical services and has a network of medical specialty care and consultation services that can meet the needs of its individuals.
1	Psychiatric Services	**Methodology:** Interviewed Jeanne Garcia, M.D., Assistant Medical Director. Interviewed John Coyle, M.D, Chairman of the P&T Committee. Interviewed Kenneth Lundgren, Pharm D., Director of Pharmacy Services. Interviewed Sherry Heber, Acting Standards Compliance Coordinator. Interviewed Joe Tipton, Health Services Specialist. Reviewed list of all individuals at the facility including current medications, diagnoses and attending physicians. Reviewed current California Department of Mental Health Psychotropic Medication Guidelines. Reviewed the charts of 36 individuals (RDN, OAA, GAC, AB, AEJ, NMK, GP, PFC, CB, RDH, RJV, GAW, GM, LDJ, RS-1, SAD, ETJ, CRL, JH, JJK,

		RS-2, LM, VHC, ELA, ELS, CRB, CL, AMM, AMI, RJJ, JLB, RDA, MAB, CKS, GW and PRP). Reviewed SO #105.10 DMH Psychotropic Medication Guidelines, including protocol regarding the use of clozapine. Reviewed summary data regarding monitoring of PRN/Stat medication use. Reviewed Psychiatry Monthly Progress Note Monitoring Form. Reviewed Psychiatry Monthly Progress Note Monitoring Summary Data (September and October 2006). Reviewed summary data regarding use of benzodiazepines, anticholinergic medications, polypharmacy and new generation antipsychotic medications (April to September 2006). Reviewed ASH AD #516.7 regarding Screening for Possible Movement Disorders Related to Neuroleptic Medication. Reviewed Tardive Dyskinesia Monitoring Form. Reviewed monitoring data regarding Tardive Dyskinesia (April to September 2006). Reviewed ASH Pharmacy Policy #692 regarding Adverse Drug Reactions (ADRs). Reviewed facility's data regarding ADRs reported since January 2005. Reviewed Report of Possible ADR Form. Reviewed last ten completed Report of Possible ADR Forms. Reviewed facility's data regarding Medication System Failures (MSF) in the past year. Reviewed MSF That Reach The Patient Form. Reviewed the last ten completed MSF Forms. Reviewed minutes of the Pharmacy and Therapeutics (P & T) Committee meetings during the past year.
1a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted	**Findings:** The facility utilizes the California Department of Mental Health guidelines that provide some general information on the use of psychotropic medications including antipsychotics, antimanics,

	professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	antidepressants, anxiolytic and hypnotic agents, stimulants, anticonvulsants, and antiparkinsonians. In addition, ASH uses the California Department of Mental Health protocol regarding the use of clozapine. The current medication guidelines still fall short of compliance with generally accepted professional standards. Specifically, they demonstrate the following significant deficiencies: 1. The guidelines are not sufficiently individualized for most of the classes of psychotropic medications. 2. The outlines fail to outline, in any systematic fashion, the indications, contraindications, precautions in use, adverse effects and outcomes for different medications. In general, the guidelines lack adequate information regarding possible risks and adverse effects and monitoring for these risks. 3. Information regarding drug-drug interactions is generally incomplete. 4. The protocol regarding the use of clozapine does not include important information regarding the following: a. Operational criteria for refractory psychotic illnesses as an indication for treatment; b. Therapeutic benefits for individuals suffering from polydipsia associated with mental illness; c. Specific monitoring for metabolic abnormalities; d. Clear guidance to staff regarding triggers for interventions to minimize the risk of myocarditis; e. The risk of delirium; f. Blood level interpretation; g. Interactions with other drugs, diet and tobacco smoking; and h. Guidelines for use in individuals who fail to respond satisfactorily.

		The facility developed and implemented a variety of monitoring mechanisms to assess compliance with items 1.a.i through 1.a.viii. These mechanisms and compliance data are reviewed for each item below. This monitoring process did not utilize complete guidelines that include information regarding indications, contraindications, screening and outcome criteria and that are derived from current literature, relevant experience and professionally accepted guidelines. In addition, the deficiencies listed under Psychiatric Assessments (C.1.c), Diagnosis (C.1.d) and Reassessments (C.1.d) are such that monitoring by ASH of this item is not based on meaningful criteria. As a result, the facility is not in compliance with items F.1.a.i through F.1.a.viii. **Compliance:** Partial. **Recommendations:** 1. Develop individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. 2. Implement recommendations listed in F.1.g. 3. Implement recommendations listed in C.1.c, C.1.d and C.1.e. 4. Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in section F.
1a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	The facility used the process of Psychiatry Monthly Progress Note Monitoring that is described in D.1.

		The following data outlines the compliance rates and corresponding indicators: 1. Identified target symptoms: 51%; and 2. Rationale for current psychopharmacology plan: 46%.
1a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	The facility has monitoring data based on the Psychiatry Monthly Progress Note Monitoring. However, the data do not address this requirement.
1a.iii	tailored to each individual's symptoms;	As above.
1a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Using the Psychiatry Monthly Progress Note Monitoring, the facility reports a compliance rate of 75% regarding the documentation of response to pharmacological treatments. This indicator is related to the requirement, but does not address it adequately.
1a.v	monitored appropriately for side effects;	The facility has monitoring data based on the above process. The following is an outline of compliance rates and indicators: 1. Monitoring of side effects, including sedation: 73%; and 2. AIMS Quarterly: 0%.
1a.vi	modified based on clinical rationales;	The facility reports compliance rate of 43% based on review of the psychopharmacological plan using the same process.
1a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.v (#1).
1a.viii	Properly documented.	Using the Psychiatry Monthly Progress Note Monitoring, the facility

		reports the following compliance rates for each component of this requirement: 1. Rationale for current psychopharmacological plan: 46%; 2. Rationale for PRN medications/ review of PRN/Stat : 13%; 3. Benefits and risks of current pharmacological treatments: 14%; 4. Response to pharmacological treatments: 75%; 5. Monitoring of side effects, including sedation: 73%; and 6. Pharmacological plan (appropriateness): 43%.
b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Findings:** The facility recognizes that the current DMH SO regarding Psychotropic Medication Guidelines and the Department of Psychiatry Manual do not include adequate guidance regarding this requirement. The PRN/Stat medication usage trigger report data have been partially implemented. The facility has data based on the Psychiatry Monthly Progress Note Monitoring. As mentioned earlier, the facility reports a compliance rate of 13% with the requirement to document appropriate rationale for PRN medications and review of PRN/Stat medications. In addition, the facility developed and implemented a Psychiatry PRN/Stat Medication/Monitoring Form to further assess its compliance with this requirement. The following is an outline of the indicators in this form and corresponding compliance findings: 1. Was the PRN clinically justified: 67%; 2. Was there documentation of effect of PRN: 94%; 3. Was an alternative to PRN medication offered: 16%; 4. Are PRN medications time-limited: 77%; 5. Is a PRN given for a specific, individualized behavior: 27%; 6. Did the psychiatrist do a face-t0-face evaluation within 24

		hours (Stat medication): 8%; 7. Did nursing staff assess patient within one hour of administration of PRN or Stat medication and document response: 83%. The different types of monitoring processes indicate discrepant findings regarding the rationale/justification for medication use. At this time, ASH has a threshold of PRN medication use of more than 15 times per month that triggers a review by the Medication Review Committee (MRC). However, as mentioned in D.1.f, chart reviews by this monitor demonstrate a pervasive trend of poor documentation of PRN and/or Stat medication use. The following are the main deficiencies: 1. There is inadequate review of the administration of PRN and Stat medications, including the circumstances that required the administration of drugs, the type and doses of drugs administered or the individual's response to the drugs. 2. PRN medications are prescribed for generic indications, typically "agitation" without specific information on the nature of behaviors that require the drug administration. 3. At times, more than one drug is ordered on a PRN basis without specification of the circumstances that require the administration of each drug. 4. There is no evidence of a face-to-face assessment by the psychiatrist within one hour of the administration of Stat medication. 5. There is no evidence of a critical review of the use of PRN and/or Stat medications in order to modify scheduled treatment and/or diagnosis based on this use. 6. PRN medications are frequently ordered when the individual's condition, as documented in psychiatric progress notes, no

		longer requires this intervention. **Compliance:** Non-compliance. **Recommendations:** 1. Update the Department of Psychiatry Manual to include all requirements in the EP regarding high-risk medication uses, including PRN and/or Stat medications. 2. Continue to monitor the use of PRN and Stat medications to ensure correction of the above deficiencies.
c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Findings:** Using the Benzodiazepine Data Collection Sheet, the Anticholinergic Data Collection Sheet, and the Polypharmacy Data Collection Sheet, eight Psychiatric Nurse Practitioners reviewed ten charts per each of 34 hospital units between April and September, 2006 to monitor adherence to the requirement in this section. Sample sizes varied per use of each form based on applicability to the chart being reviewed as follows: 1. Benzodiazepine review: 37 charts/1230 = 3% sample; 2. Anticholinergic review: 62 of 340 charts/1230 = 5% sample; and 3. Polypharmacy review: 173 of 340 charts/1230 = 14% sample The facility recognizes that the minutes of the P & T and MRC Committees do not reflect the review or use of the monitoring data and that there is no current mechanism to provide information to the WRP teams based on a trigger system regarding these medication uses. The following is an outline of the facility's findings: 1. Benzodiazepine use: An overall compliance rate of 18% is reported based on adequate indicators that address

		appropriateness of diagnostic indications, regular use, monitoring of side effects (sedation, drug dependence and cognitive decline), use for individuals with substance use disorder, use for cognitively impaired individuals and modifications of treatment. 2. Anticholinergic medication use: The facility reports an overall compliance rate of 17% based on adequate indicators that address justification of regular use, documentation of indications for use, use for elderly individuals (including monitoring of side effects) and appropriate modifications of treatment. 3. Polypharmacy use: The data show an overall compliance rate of 29% based on adequate indicators that address justification of intra-class and inter-class uses, documentation of drug-drug interactions and appropriate modifications of treatment. Reviews by this monitor of the charts of eleven individuals who are diagnosed with substance use disorder and receiving benzodiazepines as a long-term scheduled modality (RDN, OAA, GAC, AB, AEJ, NMK, GP, PFC, CB, RDH and RJV) showed a pattern of inattention to the risks of this treatment modality.. Some of these individuals (e.g. AEJ and GP) also suffer from a variety of cognitive impairments, which increases the risk of treatment. This monitor's review of the charts of ten individuals receiving long-term anticholinergic treatment as a scheduled modality (GAW, GM, LDJ, RS-1, SAD, ETJ, CRL, JH, JJK and RS-2) showed a pattern of inadequate monitoring of individuals for the associated risks. This involved individuals with cognitive impairments, including JH (Dementia, NOS) GAW and RS-1 (Cognitive disorder, NOS) who are at an increased risk. This monitor also reviewed the charts of six individuals (RS-1, CRL, JJK,

		LM, VHC and ELA) who are receiving antipsychotic polypharmacy. The review showed evidence of inadequate documentation of the justification of treatment. **Compliance:** Partial. **Recommendations:** 1. Update the Department of Psychiatry Manual to include all requirements regarding high-risk medication uses, including benzodiazepines, anticholinergics and polypharmacy. 2. Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards. 3. Consolidate the process of monitoring of all individual medications within the Drug Utilization Evaluation (DUE) Process. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	**Findings:** ASH used the New Generation Antipsychotic Medication Data Collection Sheet to monitor its compliance with this requirement. Eight Psychiatric nurse Practitioners reviewed a sample of 156 charts (13%) randomly selected from all hospital units between April and September 2006. The compliance rates varied from 1% to 90% based on adequate indicators that addressed the following areas: 1. Documentation of benefits of medications and tolerability; 2. Justification for use in individuals with metabolic disorders; 3. Use of risperidone for individuals with hyperprolactinemia; and 4. Baseline and periodic monitoring of laboratory tests, EKG and

		clinical and vital signs. This monitor reviewed the charts of seven individuals receiving new-generation antipsychotic medications, including clozapine (ELS), olanzapine (CRB and CL), risperidone (AMM), aripiprazole (AMI), and combinations of risperidone and ziprasidone (RJJ) and olanzapine and aripiprazole (JLB). These reviews included four individuals diagnosed with diabetes mellitus (AMM, AMI, RJJ and JLB). The reviews revealed inconsistent practice regarding laboratory and clinical monitoring for the risks of treatment. There was evidence of adequate monitoring for metabolic risks in most cases (AMI, RJJ, CRB, CL and JLB). However, there was lack of laboratory and clinical monitoring for endocrine risks in two cases (RJJ and AMM) and inadequate physician documentation of the status of monitoring for metabolic risks in one case (ELS) and of attempts to provide safer treatment alternatives in one case (AMM). **Compliance:** Partial. **Recommendations:** 1. Same as in recommendation #1 in F.1.a 2. Same as in C.1.g. 3. Same as in F.1.g.
e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a	**Findings:** Using the Tardive Dyskinesia Monitoring Form, eight Psychiatric Mental Health Nurse Practitioners reviewed 220 charts randomly selected from each of 34 hospital units between April and September 2006 to monitor compliance with this item. Sample sizes varied based on applicability to the chart being reviewed. The relevant findings were as follows:

	history of TD.	1. Was an AIMS done on admission (all cases): 86%; 2. Was an AIMS done at the time of the last annual physical examination: 41%; 3. If the individual has TD, was a new AIMS done every three months: 17%; 4. If the individual has a history of TD, was an AIMS done every three months: 0%; 5. Do monthly progress notes for the past three months indicate that antipsychotic treatment has been modified due to TD, history of TD or a positive AIMS result, to reduce the risk: 7%. A review by this monitor of the charts of five individuals (RDA, MAB, CKS, PRP and GW) diagnosed with TD shows the following pattern of deficiencies: 1. There is no evidence of timely assessment using AIMS. 2. The WRP fails to recognize TD as a diagnosis and as a focus for treatment and rehabilitation. 3. The WRP does not include appropriate treatment and rehabilitation interventions for TD. **Compliance:** Partial. **Recommendations:** 1. Ensure that the Department of Psychiatry Manual includes requirements regarding monitoring of individuals with TD. 2. Ensure that the diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD. 3. Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation.

		4. Improve compliance with this requirement.
f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Findings:** ASH has revised of its ADR policy to include a mechanism for intensive review of serious reactions through a P&T subcommittee composed of a physician and a pharmacist. The revision does not outline the components of the case analysis or the time frames for completion. The current system of ADR reporting continues to be ineffective due the following deficiencies: 1. There continues to be serious underreporting of ADRs. The facility reported a total of 178 reactions in 2005. For a facility with a census of more than 1200, including a large number of individuals that require complex medication regimens and very high doses of psychotropic medications, one would expect much larger numbers of ADRs to be reported. 2. ASH fails to provide adequate instruction to its clinical staff regarding the proper reporting, investigation and analysis of ADRs. Specifically, the facility does not provide information or have written guidelines regarding the requirements for : a) Classification of reporting discipline; b) Proper description of details of the reaction; c) Additional circumstances surrounding the reaction, including how reaction was discovered, relevant history, allergies, etc; d) Review of all medications that the individual was actually receiving at the time of the ADR; e) Information about all medications that are suspected or could be suspected of causing the reaction; f) A probability rating if more than one drug is suspected of causing the ADR; g) Information about type of reaction (e.g. dose-related, withdrawal, idiosyncratic, allergic, etc);

		h) Information regarding future screening; i) Physician notification and review of the ADR; j) Information on the clinical review process, including the clinical review person or team, determination of need for intensive case analysis and other actions; and k) Information regarding the timeliness and format of the Intensive case analysis of serious reactions. 3. Overall, the above deficiencies of both methodology and content in the reporting, investigation and analysis of medication variances renders the ADR system seriously inadequate for performance improvement purposes. **Compliance:** Partial. **Recommendations:** 1. Increase reporting of ADRs and provide instruction to all clinicians regarding significance of and proper methods in reporting ADRs. 2. Revise the policy and procedure regarding ADRs to include an updated data collection tool. The procedure and the tool must correct the deficiencies identified above. 3. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 4. Develop and implement a format for the intensive case analysis to include proper discussion of history/circumstances, preventability, contributing factors and recommendations.
g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring	**Findings:** ASH has completed only one DUE regarding the use of sliding scale insulin for individuals with diabetes mellitus. The DUE resulted in specific recommendations to improve facility's performance regarding

	requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	the prescription of basal insulin therapies. The facility has yet to conduct a DUE regarding the use of psychotropic medications and to develop individualized medication guidelines to serve as the basis for a DUE policy and procedure. The facility cites the shortage of pharmacy staff as the main barrier to compliance with this requirement. **Compliance:** Partial. **Recommendations:** 1. Same as recommendation #1 in F.1.a. 2. Develop and implement a policy and procedure to codify a DUE system based on established individualized medication guidelines. 3. Ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 4. Determine the criteria by which the medications are evaluated, the frequency of evaluation, the indicators to be measured, the DUE data collection form, acceptable sample size, and acceptable thresholds of compliance. 5. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 6. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Findings:** ASH collects data regarding medication variances (errors). The current system, known as medication system failures (MSF), contains the important categories of prescribing, dispensing, transcription and administration variances. The data collection tools include a severity

		scale of the outcome of the variance. The facility has data regarding facility-wide trends in some actual variances and some remedial steps taken in response to this analysis. The facility has a policy and procedure that describes the current system. The current system of MVR continues to be ineffective due to the following deficiencies: 1. ASH fails to ensure that clinical staff is educated regarding the proper methods of reporting medication variances and of providing information that aids the proper investigation and analysis of the variances. The facility does not provide information or have written guidelines to staff regarding: a) Classification of reporting discipline; b) Proper description of details of the variance; c) Additional facts involving the variance, including how the variance was discovered, how the variance was perpetuated, relevant individual history, etc.; d) Physician and pharmacist notification both in actual and in potential variances; e) Description of the full chain of events involving the variance; f) Classification of potential and actual variances; g) All medications involved and their classification; and h) The route of medication administration. 2. The system is focused on limited categories of actual variances and ignores several important categories that have critical significance in performance improvement. These categories include all potential medication variances and several actual variances. Examples include information regarding: a) Failure by prescribing physician to include proper or any parameters for clinical monitoring by the nursing staff; b) Variances in the ordering and/or procurement of the drug;

		c) Variances in the storage of the medication; d) Administration variances such as wrong technique, lack of clinical monitoring, etc.; e) Documentation variances such as medication not being charted as given; and f) Variances in medication security, including found medications. 3. The MSF data collection tool does not include information on critical breakdown points in the common situations that involve more than one variance. This failure seriously limits the ability of ASH to direct its performance improvement efforts to the root variance. 4. The data collection tool includes inadequate outline of factors contributing to the variance. For example, the tool has an incomplete list of contributing human factors and it ignores other critical categories including environmental factors, communication issues, dispensing/storage/administration system variables and product-related issues. 5. Regarding individual's outcomes, the data collection tool is limited to three categories of inconsequential, serious and critical. This classification is not aligned with the current generally accepted nine categories of outcome that facilitate analysis for performance improvement purposes. 6. ASH fails to ensure a system of intensive case analysis of medication variances based on established thresholds. 7. The current system of MSF is not integrated in any meaningful fashion in the activities of the P&T Committee, the MRC, the Department of Psychiatry or the Department of Medicine. As mentioned earlier, the current systemic reviews of MSF are marked by parallel and disintegrated processes. 8. ASH fails to collect and analyze data regarding individual and group practitioner trends and patterns in medication variances. As a result, there is no evidence of performance improvement

		activity based on actual analysis. Overall, the above deficiencies of both methodology and content in the reporting, investigation and analysis of medication variances renders the MSF system seriously inadequate for performance improvement purposes. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. 2. Provide instruction to all clinicians regarding the significance of and proper methods in MVR. 3. Develop a policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. 4. Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. 5. Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. 6. Ensure that MVR is a non-punitive process.
i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted	**Findings:** ASH did not present data to indicate proper tracking and identification of individual and group practitioner trends regarding the areas identified in this section.

	professional standards of care.	The above mentioned deficiencies in F.1.a through F.1.h must be addressed and corrected prior to the development of meaningful practitioner trend data. **Compliance:** Partial. **Recommendations:** 1. Same as in F.1.a. through F.1.h. 2. Improve IT resources to the pharmacy department to facilitate the development of databases regarding medication use.
j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Findings:** Same as in F.1.b. and F.1.i. **Compliance:** Non-compliance. **Recommendation:** Same as above.
k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Findings:** Same as above. **Compliance:** Non-compliance. **Recommendation:** Same as above.
l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in	**Findings:** As mentioned earlier, ASH has a peer review mechanism that is utilized in the evaluation of physicians' performance. However, the facility does

	appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	not have a data-driven process that is aligned with the different requirements of the EP and that can be used to address this requirement. The findings outlined in team leadership (C.1.b), interdisciplinary functioning (C.1.c.), the integration of behavioral and pharmacological treatments (D.1.f.v.iii.) and medication management (F.1.a throughF.1.h.) are applicable to this item. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a physician's performance quality profile and ensure that the indicators address and integrate all the medication management requirements outlined in section F. 2. Ensure that the Department of Psychiatry Manual includes clear expectations regarding medication management that are aligned with all the requirements in section F. 3. Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Findings**: The facility has monitoring data that is presented in F.1.c. The findings of deficiencies listed in F.1.c indicate that the current system of clinical oversight is inadequate. **Recommendations:** 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department.

m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Findings**: The facility's and this monitor's findings listed in F.1.e indicate that ASH does not have an adequate clinical oversight system that ensures timely and appropriate monitoring of all individuals suffering from TD and the recognition of TD as one of the foci of hospitalization that require specialized treatment and/or rehabilitation objectives and interventions. **Recommendations:** 1. Same as in F.1.e. 2. Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience. 3. Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD.
m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Findings**: Refer to F.1.d for the findings by the facility and this monitor. **Recommendations:** Same as in F.1.d. and F.1.g.

n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Findings:** The facility has monitoring data to assess the appropriateness of benzodiazepine use for individuals diagnosed with substance use disorders. The process of self-monitoring is the same as in F.1.c. The compliance rate that is relevant to this requirement is 10%. This monitor's findings in C.2.o and F.1.c. indicate a pattern of deficiencies that must be addressed and corrected to ensure compliance with this section. **Compliance:** Partial. **Recommendations:** Same as in C.2.o and F.1.c.
o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	
2	**Psychological Services**	
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed Karen Sheppard, Ph.D., Acting Chief of Psychology. Interviewed Diane Imrem, Psy.D., Enhancement Coordinator. Interviewed Jeffery Teuber, Ph.D., Positive Behavior Support Coordinator. Interviewed Christine Mathiesen, Psy.D., Neuropsychologist, Director EOS. Interviewed Mr. John Rich, BY CHOICE coordinator Interviewed Deirdre Phifer-Davis, BY CHOICE store technician. Interviewed Pat O'Rourke, RN, Supervisor Program I.

		Interviewed Rafael Romero, Unit Supervisor, Program II. Interviewed Individuals, SM,JM, Reviewed charts of 22 individuals (LW, RT, TJ , JZ, MR, PS, JC, SR, CS, IW, DM, DC, RC, DB, JJ, CH, EM, JH, JC, RP, RG and MB**)**. Reviewed BY CHOICE Competency and Fidelity Protocol and Survey Reviewed BY CHOICE Manual. Reviewed Memberships of PBS Teams. Reviewed AD-409 for Rehabilitation Therapy Treatment and Activity Services. Reviewed American Psychological Association (APA) Ethics Standards of Practice. Reviewed Mall Curriculum. Reviewed Psychology Protocols and Assessment Tools. Reviewed Functional Assessments. Reviewed BCC treatment plans. Reviewed DMH audit forms. Reviewed WRP audit forms. Reviewed list of individuals on PBS plans. Reviewed a sample of personnel CVs. Reviewed personnel certification and licensure documents. Reviewed PBS monitoring form. Reviewed BCC meeting schedules and minutes. Reviewed PBS Integrity checklist. Reviewed ASH Skills Profile Manual (Revised 7/28/04). Reviewed Mall Activity Schedule. Reviewed Neuropsychology section draft manual. Observed unit Mall sessions. Observed WPR team conferences Observed BY CHOICE store.
a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1	**Findings**: The State has established guidelines on the composition, duties, responsibilities and regulations governing the PBS teams. The guidelines

	registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	are aligned with the requirements of the EP. The hospital currently has four out of five members of one PBS team. The current team-to-individual ratio is not in line with the EP requirement of a ratio of 1:300. The PBS team members interviewed demonstrated competence in their understanding of current generally accepted standards in Positive Behavior Support. Information from PBS team members and BCC team members showed that the referral process to the PBS teams is not properly understood or followed by WRP teams and unit staff. Referral of cases to the PCMC instead of using the PBS-BCC pathway is not in line with requirements of the EP. Interviews of PBS team members and others in the department reveal a severe shortage of resources for them to fully accomplish the job mandate placed upon them. Lack of resources includes additional PBS teams. Training has not been provided across all units and programs at ASH. Given the high numbers of episodes and hours of seclusion and restraint in the hospital, the number of PBS plans is significantly small. **Recommendations:** 1. Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral, what is expected once a referral is made, and timelines). 2. Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. 3. Identify in the manual specific evidence-based tools to use for each type of assessment.

		4. Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP. 5. Ensure that all direct care staff system-wide are competent in the principles and practice of PBS. 6. Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in ASH.
a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Findings:** This monitor evaluated 14 Functional Assessments and 14 PBS plans using the PBS Monitoring Tool. The following patterns were identified: 1. The individual's Wellness and Recovery Plan (WRP) Team is involved in the assessment and intervention process—100% in compliance; 2. Broad goals of intervention were determined—100% in compliance; 3. At least one specific behavior of concern was defined in clear, observable and measurable terms—36% showed compliance and 64% partial compliance; 4. Baseline estimate of the maladaptive behavior was established in terms of objective measure—100% in compliance; 5. Pertinent records were reviewed—36% in partial compliance and 64% not in compliance; 6. Structural assessments (e.g., ecological, sleep, medication effects, mall attendance, etc) were conducted, as needed, to determine broader variables affecting the individual's behavior—0% in compliance; 7. Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities—100% in partial compliance; 8. Direct observations were conducted across relevant

		circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate—14% in partial compliance and 86% not in compliance; 9. Other assessment tools (e.g., rating scales, checklists) were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior- 100% not in compliance; 10. Patterns were identified from the data collected that included (a) circumstances in which the behavior was most and least present (e.g. when, where, and with whom) and (b) specific functions the behavior appeared to serve the individual (i.e. what the individual gets or avoids by engaging in the behaviors of concern)--43% partial compliance and 57% not in compliance; 11. Broader variables (e.g., activity patterns, curriculum) that may be affecting the individual's behavior were identified—50% in partial compliance and 50% not in compliance; 12. Patterns were summarized into written hypotheses based on structural and/or functional assessments. These statements were clear, concise, and based on data—21% in partial compliance and 79% not in compliance; 13. Intervention strategies were clearly linked to the hypotheses derived from the structural and/or functional assessments—21% in partial compliance and 79% not in compliance; 14. The individual's PBS Team designed a Positive Behavior Support plan (PBS plan) collaboratively with the individual's WRP Team that includes: description of the behavior, patterns identified through the structural and functional assessments and goals of intervention—100% in partial compliance; 15. Modifications to the social, environmental or cultural milieu that may prevent the behavior and/or increase the likelihood of alternative appropriate behavior(s)—50% in partial compliance and 50% not in compliance;

		16.	Specific behaviors (skills) to be taught and/or reinforced that will: (a) achieve the same function as the maladaptive behavior, and (b) allow the individual to cope more effectively with his/her circumstances—21% in partial compliance and 79% not in compliance;
		17.	Strategies for managing consequences so that reinforcement is maximized for positive behavior and minimized for behavior of concern, without the use of aversive or punishment contingencies—14% in partial compliance and 86% not in compliance;
		18.	The PBS plan is clearly specified in the Objective and Intervention sections of the individual's Wellness and Recovery Plan. The PBS Plan itself need not be included in the individual's WRP—50% in partial compliance and 50% not in compliance;
		19.	If necessary to insure safety and rapid de-escalation of the individual's maladaptive behavior, crisis management procedures and criteria for their use and termination were determined and documented—79% not in compliance and 21% not applicable;
		20.	Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity (>90%)—0% in compliance;
		21.	Implementation of the PBS plan is monitored to ensure that strategies are used consistently across all intervention settings—0% in compliance;
		22.	Objective information is collected to evaluate the effectiveness of the PBS plan. This information includes decreases in maladaptive behavior—21% in partial compliance and 79% not in compliance;
		23.	Increases in replacement skills and/or alternative behaviors--21% in partial compliance, 79% not in compliance;
		24.	Achievement of broader goals—0% in compliance;
		25.	Durability of behavior change—0% in compliance;
		26.	At scheduled Wellness and Recovery Plan Conferences, the

		individual's WRP team reviews the individual's progress and a PBS Team member or the WRP Team psychologist makes necessary adjustments to the PBS plan, as needed—36% partial compliance and 64% not in compliance. PBS plans are generally not linked to the functional assessment. When behaviors are tracked, they tend to focus on the target behavior. Data from most plans show great variance and are not meaningful. The PBS team seems to end up implementing the plan and not the unit staff. ASH self-assessment showed that response to behavioral interventions was noted in only 5 out of 15 WRP team conferences. PBS team members rarely attend the WRP conferences for training and exchange of information. Fidelity checks are rarely conducted. PBS team training modality of staff is limited to verbal communication and review of PBS plans. **Compliance:** Partial **Recommendations:** 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRP conferences of the individual. 4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is

		necessary to improve treatment implementation. 5. The PBS teams, WRP teams and the BCC require training to fully understand their roles, agenda at the BCC and tracking of referrals made to the BCC. 6. Ensure that all PBS team leaders receive training in the development of structural assessment, functional assessment and functional analysis, and the development and implementation of PBS plans. 7. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling). 8. Integrate a response to triggers in the referral process.
a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Findings:** ASH currently is implementing the BY CHOICE program in stages. The BY CHOICE program is fully functioning in Programs II, VI, and IV, and has only been recently introduced in Program V. Review of charts showed that documentation is poor. For example, charts on DC, RC, DB, CH, and JH did not have any documentation on their BY CHOICE participation in their WRPs. According to the BY CHOICE Coordinator, a number of difficulties including staff shortage, limited resources, and lack of time for meetings and training are obstacles to full program implementation. Individuals in the BY CHOICE programs complained that the price is too high for "meaningful rewards." A number of individuals in ASH have obtained the BY CHOICE price list from other State Hospitals and are comparing the prices in the other facilities against the price list in ASH. The prices across hospitals should be comparable.

		The number of staff dedicated to the BY CHOICE program is too few to properly manage the program in a large facility such as ASH. Per the Coordinator, the incentive stores' operating hours are adequate for individuals to exchange their BY CHOICE points. Individuals reported that they like the BY CHOICE program. BY CHOICE matters are not regularly discussed at WRP meetings. Only one of the five WRP conferences observed by the monitor discussed the BY CHOICE program with the individual. ASH self-assessment concurred with the monitor's findings. The BY CHOICE coordinator audited 65 charts (five charts from each of the 13 units). His data showed that only 26% of the charts audited had any mention of the individual's BY CHOICE program. **Compliance:** Partial. **Recommendations:** 1. Ensure all staff correctly implements the BY CHOICE program. 2. Implement the program as per the manual. 3. Ensure that the program has additional staff members, computers and software. 4. BY CHOICE point allocation should be determined by the individual at the WRP conference, with facilitation by the staff. 5. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRP conference.
b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Findings:** Dr. Karen Sheppard, Acting Chief of Psychology, is responsible for the administration of the PBST and the BY CHOICE incentive program.

		Compliance: Substantial. **Recommendations:** 1. Use the Special Order as the ASH AD. 2. Implement the AD. 3. Follow the requirements of the EP.
c	Each State Hospital shall ensure that:	**Compliance:** Partial.
c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Findings**: The quality of the assessments reviewed failed to meet generally accepted professional standards. Structural assessments were not done even when clearly indicated. There is poor understanding among direct care staff of what structural and functional assessments are. ASH functional assessments are missing critical components of a functional assessment. They lack QABF-MIs, direct observations, the use of any evidence-based tools, and they do not generate a hypothesis based on data. **Recommendations:** 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. 2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Findings**: Many of the plans reviewed by this monitor did not have well-formulated behavioral hypotheses. ASH self-assessment showed the same findings. Hypothesis development from structural and functional assessments is

		very poor. Twenty percent of the plans met partial compliance, and 80% did not meet compliance. **Recommendations:** Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.
c.iii	There is documentation of previous behavioral interventions and their effects;	**Findings**: ASH self-assessment showed that 12 out of 16 functional assessments reviewed did not meet the requirements for this item. The monitor's finding was in agreement with ASH self-assessment data. **Recommendations:** 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions.
c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Findings**: No aversive or punishment contingencies were evident among the behavioral interventions reviewed. However, most of the behavioral interventions did not conform to the PBS model. **Recommendation:** Ensure that all behavioral interventions are based on a positive behavior support model without any use of aversive or punishment contingencies.
c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Findings**: There is no documentation to indicate that behavioral interventions were properly and consistently implemented as designed across all settings. PBS team leaders reported time and personnel constraints in tracking and monitoring this requirement.

		Recommendations: 1. Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including Mall, vocational and education settings. 3. Conduct regular fidelity checks
c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Findings**: ASH's self-assessment showed that a number of steps are being taken to address this requirement. A system of three levels is put in place as triggers that require different intensities of treatment implementation. A pilot is being implemented for triggers regarding the use PRN and Stat medication. Reportedly, all programs have been trained on this system. ASH's self-assessment also indicates that there has been no referral to BCC (level-three referral) over the past six months. Clearly, the system is not working as it should given that there are nearly 722 individuals that require one-to-one monitoring and/or seclusion and/or restraints, and hundreds of individuals who have significant behavioral issues. Many of these individuals may in fact be going to the PCMC rather than to the PBS-BCC pathway as mandated by the EP. ASH is not in compliance with the EP on this item. ASH self-assessment on this item also states that "there is a process for flow of data reporting and analysis to the Chief of Psychology who has the responsibility for ensuring the intervention through the BCC." However, the monitor was given to understand that cases are also referred directly to PCMC.

		Recommendations: 1. Continue to refine the trigger system. 2. Ensure that staff is aware of the PBS-BCC pathway. 3. Using the PCMC in place of the BCC is a violation of EP.
c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Findings**: ASH self-assessment showed that only ten Positive Behavior Support consultations considered and addressed other treatment modalities, in this case drug therapies. **Recommendations:** 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Integrate all behavioral interventions with other treatment modalities, including drug therapy.
c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Findings**: ASH's self-assessment data showed that this item is in partial compliance. WRP teams often fail to focus on this item during WRP conferences. . **Recommendations:** 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP Plan as outlined in the DMH WRP Manual. 2. Ensure that WRP teams are aware of the DMH WRP Manual, as the Manual specifies how this is done.
c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery	**Findings**: ASH is deficient on this item. ASH self-assessment indicates that four individuals did not have WRP

	Plan	meetings; one did not have his PBS mentioned in the present status section of the case formulation of his WRP, and ten had PBS plans noted in the present status section. The monitor's review of PBS data and WRP plans showed that this requirement is met only 36% of the time. **Recommendation:** Update all PBS plans as indicated by outcome data and document it at every scheduled WRP conference in the present status section of the individual's case formulation.
c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	**Findings**: The PBS team consists of two members: a Psychologist, who functions as the Coordinator, and a Psychiatric Nurse Practitioner. Both members showed good understanding of PBS and its role within the recovery model. The coordinator has a strong education and clinical experience in behavioral interventions. The coordinator also evidenced good clinical acumen when discussing staff training, case formulation, and data analysis. Documentation of competency-based staff training in implementing behavioral interventions is lacking. Information from staff and ASH's self-assessment showed that staff training in behavioral interventions generally is limited to verbal communication and review of PBS plans. Further, it is also noted in the self-assessment that PBS team members do not usually attend WRP conferences or duty shift times for exchange of information and training. **Recommendation:** Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible and have performance improvement measures in place for monitoring the implementation of

		such interventions.
c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Findings**: Information from Dr. Karen Sheppard, Acting Chief of Psychology and the two PBS team members indicated that this in large part is true. However, in practice, the PBS team members are forced to carry additional workloads such as data collation and graphing. This is due to the shortage of staffing. **Recommendations:** 1. Ensure that all PBS team members provide PBS services full-time until the needs of all individuals requiring behavioral interventions are met. 2. Ensure that the Chief of Psychology has responsibility to determine PBS team members' duties. 3. Hire additional staff to add PBS teams to meet the 1:300 ratio. 4. Hire PBS support staff for tasks including data management, and graphing.
c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Findings**: ASH is deficient in this requirement. ASH self-assessment showed only 26% compliance to this item. BY CHOICE program is not fully operational throughout the system. **Recommendations:** 1. Implement BY CHOICE system-wide 2. Ensure that By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan. 3. Fix the BY CHOICE point allocation database to make it more user-friendly.
d	Each State hospital shall ensure that it has at least one	**Findings:**

	developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	ASH does not have a full Developmental and Cognitive Abilities Team (DCAT), consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. ASH's self-assessment shows that a registered nurse has been hired for the DCAT. Recruitment of the other members of the team is at varying stages in the hiring process. **Compliance:** Non-compliance. **Recommendations:** 1. Ensure there is a DCAT team. 2. Ensure that DCAT team members' primary responsibility is consistent with EP. 3. Ensure that all DCAT team members receive appropriate training.
e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Findings:** Currently, Dr. Karen Sheppard, Acting Chief of Psychology, is chair of the Behavior Consultation Committee (BCC), and the co-chair is Jeanne Garcia, M.D., Senior Psychiatrist. Review of BCC meeting schedule and minutes shows that meetings, especially for the year 2006, are infrequent. BCC referral is low. Possible factors contributing to the low referral include poor data-based decision-making, difficulty establishing integrity of treatment implementation, or poorly defined triggers. BCC lacks the authority over the implementation of their plans. Unit staff considers BCC and PBS teams as consultants rather than an integral unit in the hierarchy of services. BCC seems to operate parallel to PCMC, a medical committee said to be dealing with "high risk' behaviors requiring 1:1 monitoring and restraint

		and seclusion. The current BCC leadership feels that the PCMC is necessary because BCC is not able to deal with the so called "high risk' cases. This set-up is unique to ASH. The other three state hospitals function well under the PBS-BCC pathway. It is difficult to understand why the medical staff in PCMC cannot be incorporated into the BCC to provide their expert services to the individual's through BCC. Independence of practice and clinical decision-making by administrators was mentioned as reasons for having the PCMC. This is not an adequate justification for having the PCMC. The EP lays out membership requirements and the scope of responsibility of BCC. The focus of BCC is clinical, as evidenced by Special Order #129, which calls it "a clinical consultation committee." The inclusion of clinical administrator and division chiefs is to provide necessary resources to support the implementation of the BCC's clinical "guidance," "support" and "recommendations" to the WRP team (AD # 416). The lack of full implementation of the BCC means that the facility is not in compliance with this aspect of the enhancement plan. The EP indicates that seclusion/restraint is only approved in emergency situations and is not to be used as a regular part of the individual's plan of care. Usage of restraint or seclusion as part of a planned intervention, be it WRP or PCMC plan, means that the facility is not in compliance with this aspect of the EP. **Compliance:** Partial. **Recommendations:** 1. Ensure that the BCC functions as intended and expressed by the EP as outlined in Special Order 129 and AD 416. 2. Establish proper guidelines for referral to BCC 3. Ensure that staff is informed on the sequence of steps for

		referrals to the BCC. 4. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 5. Include PBS team members and WRP team members at BCC team meetings to problem-solve as to why plans are not fully implemented 6. Set up a system of accountability to ensure that BCC plans are properly implemented when indicated.
f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Findings:** ASH is deficient in this requirement. As of October, 2006, ASH had 2 neuropsychologists. According to Dr. Mathiesen (Neuropsychologist, Director of Evaluation and Outcome Services), at present neuropsychological assessments are backlogged by as many as four months, and it would require at a minimum of five to seven neuropsychologists for timely completion of evaluations. Furthermore, the current census is such that the neuropsychologists are unable to provide any needed services beyond remediation and diagnostic support. Dr. Mathiesen forwarded a well-thought-out plan of needs to hire and retain neuropsychologists, and to provide the quality of clinical care these professionals are capable of in the interest of improving the quality of care for individuals in ASH. This list has been copied to the Clinical Administrator and the Acting Chief of Psychology. **Compliance:** Partial. **Recommendations:** 1. Ensure that WRP teams, especially psychiatrists and psychologists, make referrals, when appropriate, for

		neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Findings:** ASH's self-assessment shows that this item is addressed through AD # 416. The directive was approved on September 5, 2006. The next step in the process is for the Psychology Department to integrate this item into the Department of Psychology Privileging Document and forward it for final approval. **Compliance:** Partial. **Recommendations:** 1. The hospital and/or state must provide psychologists the authority to write orders as specified in the EP. 2. Ensure that this authority is fully approved and implemented.
3	**Nursing Services**	
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed Carol Constien, Coordinator of Nursing Services. Interviewed Al Joachim, Acting Assistant Coordinator of Nursing Services/Health Services Specialist (HSS). Interviewed Arlene Gasch, HSS. Interviewed Donna Hunt, HSS. Interviewed Vickie Vinke, HSS Interviewed Sharon McCartney, HSS Reviewed Medication Administration Monitoring data. Reviewed Statewide Medication Administration Monitoring Form raw

		data. Reviewed DMH Statewide 24-Hour Noc Audit Monitoring Form. Reviewed DMH Nursing Services PRN/Stat Medications Monitoring Form. Reviewed the PRN Pain Management Flow sheet form. Reviewed DMH Nursing Services Nursing Monitoring: Nursing Interventions tool and Instructions. Reviewed DMH WRP Conference Process Observation Results By Response data. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For That Individual. Reviewed Nursing Services: Nursing Staff Working With An Individual Shall Be Familiar With The Goals, Objectives, and Interventions For That Individual Monitoring Form. Reviewed DMH Nursing Services: Shift Change Monitoring Form and Instructions. Reviewed DMH WRPC CET Team Attendance and Nursing Participation Monitoring form and Instructions. Reviewed DMH Monitoring Form for Bed-Bound Individuals. Reviewed MOSES Monitoring Tool (draft). Reviewed Section III Integrated Therapeutic and Rehabilitation Services Planning tool (draft). Attended shift report for Unit I.
a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
a.i	safe administration of PRN medications and Stat medications;	**Findings**: ASH reported that of 41 nursing policies (NPs), two have been revised

		and 32 have been partially revised, but are still in need of additions to meet compliance with this requirement. **Recommendations:** 1. Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications. 2. Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications. 3. Report PRN medication data and Stat medication data separately. 4. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. 5. Revise Statewide Medication Administration Monitoring Tool to reflect PRN medication and Stat medication data separately.
a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Findings**: ASH reported that documentation of PRN and Stat Medication use on the Medication Administration Records (MARs) is being reviewed nightly, but the data is not being systemically gathered or analyzed. ASH conducted a random sampling of 20 individuals (2 each from 10 units) and reported 100% compliance with documentation of circumstances requiring PRN/Stat medications and 90% compliance with documentation of individuals' response to PRN/Stat medications. However, on each monitoring tool reviewed, I noted that PRN and Stat medication data were not monitored or tracked separately. From my review of three individuals (JS, WT and RW) who received several PRN medications, none were found to have adequate documentation relating to this requirement. From my review of seven

		individuals (JB, JP, JT, JG, SB, NC and SW) who received a Stat medication, all seven had documentation regarding circumstances requiring the medication. **Recommendations:** 1. Revise all monitoring forms to reflect PRN and Stat data separately. 2. Revise policies and procedures to reflect this requirement. 3. Provide staff training on policy and procedure revisions.
a.iii	documentation of the individual's response to PRN and Stat medication.	**Findings**: ASH reported 50% compliance with this requirement. However, PRN and Stat medication data were reported together. From my review of the three individuals who received a PRN, all only had the word "effective" documented as to the individual's response. From review of the seven individuals who received a Stat medication, all seven basically documented "effective" as the description of the individual's response. **Recommendations:** 1. Ensure staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. 2. Clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat medications to ensure consistent data. 3. Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications.
b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or	**Findings:** ASH's current policies and procedures do not adequately address this

	the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	requirement. ASH reported confusion regarding medication variances and medication errors. ASH does report failures to sign the Medication Treatment Record (MTR) and the controlled medication logs as medication documentation errors. **Compliance:** Partial. **Recommendations:** 1. Revise monitoring tools to include this requirement. 2. Revise policies and procedures regarding medication variances to include failures to properly sign the MTR or the controlled medication log as reportable medication variances. 3. Develop and implement a system to monitor appropriate follow-up to prevent recurrence of such variances. 4. Provide training to staff regarding the above.
c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Findings:** There is no monitoring instrument or tracking system in place addressing the elements of this EP requirement. The monitoring and tracking tools that ASH included for this requirement do not reflect the elements of this cell. Currently there are four programs at ASH that have converted to the WRP format: II, IV, V, and VI. Many of the nursing interventions reviewed that were included in the WRPs from these units were not proactive and include meaningless interventions such as "will monitor" without including what was to be monitored, how often, where it should be documented, when it would be reviewed and by who. In addition, there is generally little clinical objective data that is generated from most of the nursing interventions to determine if

		individuals are better or worse. I also noted that many of the interventions contained in the WRPs were not written in observable, behavioral, and/or measurable terms. **Compliance:** Partial. **Recommendations:** 1. Revise policies and procedures to reflect this requirement. 1. Ensure that all nursing and psychiatric technicians are competent with regard to the WRP and the Recovery Model. 2. Ensure that interventions are written in observable, behavioral, and/or measurable terms. 3. Develop and implement proactive interventions related to the individuals' needs and risks. 4. Develop and implement a monitoring instrument and tracking system addressing this requirement.
d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Findings:** There is currently no monitoring instrument or tracking system in place addressing the elements of this EP requirement. A random sample was audited from a monitoring that has been implemented at ASH on six units for 12 nurses. ASH reported 25% compliance for familiarity with individuals' goals and zero% compliance for familiarity with objectives. No data were presented for interventions. **Compliance:** Non-compliance. **Recommendation:** Develop and implement a statewide monitoring instrument and tracking

		system addressing the elements of this requirement.
e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Findings:** ASH does not have a monitoring instrument or tracking system in place addressing all the elements of this requirement. ASH did submit a monitoring instrument addressing shift changes. However, no data was presented for this element. I observed a shift change report on unit I for day and evening change of shift. There appeared to be no system in place guiding what information should be passed along to the oncoming shift. Much of the detailed information, such as diagnoses and health status information, was provided to me by the unit supervisor. **Compliance:** Non-compliance **Recommendations:** 1. Develop and implement a system for monitoring and tracking the elements of this requirement. 2. Develop and implement policies and procedures addressing criteria for shift change reports.
f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Findings**: At ASH, the program HSS or designee reportedly certifies staff and the Medication Administration Competency Validation Practicum Check Sheet is placed in the employee's personnel file. The initial monitoring is completed one time for competency and then every two years. However, there is no ongoing audit or monitoring system in place.

		The statewide Medication Administration Monitoring form has not been implemented thus far. However, the tool was used to do a random, limited sample audit. ASH reported that 63 medication passes were observed over a three-day period. The following are the compliance rates and corresponding indicators: 1. Verbalizing generic and trade names of medications administered: 100%; 2. .Describing therapeutic effects, usual doses, and routes of medications: 100%; 3. Differentiating expected side effects from adverse reactions: (100%); 4. Explaining sliding scale for regular insulin: 82%; and 5. Verbalizing symptoms and interventions of hypo-hyperglycemia: 82%. **Recommendations:** 1. Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. 2. Develop and implement system to ensure that every nurse that administers medication is observed on a quarterly basis.
f.ii	education is provided to individuals during medication administration;	**Findings**: ASH reported that there is no ongoing monitoring or data collection process addressing this requirement. However, limited data were presented collected from the random sample described above in f.i. ASH reported 60% compliance with this requirement. **Recommendations:** 1. As in f.i 2. Ensure staff competency regarding the implementation of this

		requirement.
f.iii	nursing staff are following the appropriate medication administration protocol; and	**Findings**: ASH reported that there is no ongoing monitoring or data collection process addressing this requirement. However, limited data were presented collected from the random sample described above f.i. ASH reported the following compliance rates with components of this requirement: 1. Applies principles of asepsis: 100%; 2. Organizes medications no more than one hour prior to administration: 100%; 3. Identifies individual by name and photograph: 100%; 4. Checks for allergies: 65%; 5. Measures, interprets, records BP and pulse prior to administration of cardiac and hypertensive medications; withholds as indicated: 100%; 6. Opens/pours medication in front of individual: 100%; 7. Correctly administers crushed and liquid medications: 100%; 8. Checks medication with MAR 3 times: 85%; 9. Ensures individual swallowed medications: 100%; 10. Applies proper technique with syringes: 100%; 11. Ensures privacy and confidentiality: 100%; and 12. Properly administers eye-ear drops and inhalers/spray: 100%. **Recommendation:** Same as in f.i
f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Findings**: ASH reported that there is no ongoing monitoring or data collection process addressing this requirement. However, limited data were

		collected from the random sample described above f.i. ASH reported 100% compliance with the following indicators: 1. Documents and signs out medications correctly; and 2. Documents on MAR immediately after administration. **Recommendation:** Develop and implement a monitoring instrument and tracking system addressing all the elements in this requirement.
g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Findings:** ASH reported there is no monitoring instrument or tracking system in place addressing this requirement. **Compliance:** Non-compliance. **Recommendations:** 1. Revise policies and procedures to address this requirement. 2. Develop and implement a monitoring instrument and tracking system to address this requirement.
h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.
h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Findings**: ASH reported there is no monitoring instrument or tracking system in place addressing this requirement. **Recommendations:** Develop and implement a monitoring instrument and tracking system to

		address this requirement.
h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Findings**: There is no system in place to monitor and track this requirement. The data provided by the nursing department did not reflect the implementation of this requirement. **Recommendations:** 1. Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. 2. Develop and implement a system to adequately monitor and track this requirement.
h.iii	positive behavior support principles.	**Findings**: ASH reported 60% compliance with hospital-wide competency-based training in Positive Behavior Support (PBS). **Recommendations:** 1. Develop and implement a system to ensure that nursing staff, including psychiatric technicians, attend PBS training. 2. Continue to monitor and track attendance at PBS training.
i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Findings:** ASH reported that staff is initially certified and then re-certified every two years. The certification includes documentation of administration of medication, by post-test and by observation of competency by HSS. However, there is no regular, ongoing audit or monitoring system in place. **Compliance:** Partial.

		Recommendations: Develop and implement system to ensure compliance with this requirement.
4	**Rehabilitation Therapy Services**	
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed LaDonna DeCou, Chief of Rehabilitation Services, Program Consultant. Interviewed Mary Jo Bonneville-Waugh, RN Supervisor for Central Medical Services (Stayed for a portion of the interview) Interviewed Doug Shelton, M.D., Chief Physician and Surgeon, Director of Central Medical Services (Stayed for a portion of the interview). Interviewed Elizabeth Price, SLP. Reviewed Rehabilitation Service Staff Roster. Reviewed Title 22. Reviewed ASH Policy for Rehabilitation Therapy Assessment (draft). Reviewed ASH Rehabilitation Services Manual. Reviewed Integrated Rehabilitation Therapy Assessment tool (draft). Reviewed Integrated Rehabilitation Therapy Assessment audit. Reviewed Individual Training Report for past three years for Rehabilitation staff. Reviewed ASH Patient Education Tools for Crutch Fitting and Wheel Chairs. Reviewed Rehabilitation Therapy Documentation Audit tool and raw data. Reviewed charts of ten individuals LS, HS, DR, RA, CB, RM, RC, FH, JN and ED. Reviewed list of individuals with adaptive equipment. Reviewed list of individuals at risk for choking. Reviewed list of individuals at risk for dysphagia and aspiration. Reviewed list of individuals with hearing aids. Observed individuals in wheelchairs on Unit I and in facility hallways. Reviewed PT caseloads.

		Reviewed PT and Speech assessments. Received shift report and did walking rounds with Supervising RN, Pat O'Rouke on Unit I.
a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
a.i	the provision of direct services by rehabilitation therapy services staff; and	**Findings:** ASH's rehabilitation therapy services policies and procedures do not include the principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, or principles of recovery. In addition, there are no OT services provided at ASH and PT and Speech Therapy are not integrated into the Rehabilitation Department. **Recommendations:** 1. Revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. 2. Obtain the services of OT. 3. Integrate OT, PT, and Speech Therapy into the Rehabilitation Department as well as into the WRP and team process.
a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Findings:** ASH reported that there is no oversight provided by the specialty therapies (OT, PT and Speech Therapy) of individualized programs that are implemented by nursing staff. **Recommendations:** 1. Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized PT programs. 2. Develop and implement a monitoring system to ensure that

		oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring.
b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Findings:** ASH reported that some competency-based training occurs in orientation. However, the majority of training addressing this requirement is done informally and without supporting documentation nor is it competency-based. There is no system in place to monitor this requirement. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a system to provide and document competency-based training on this requirement. 2. Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement.
c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Findings:** From my review, there is no system in place to ensure compliance with the key elements of this requirement. As mentioned in the Rehabilitation Therapy Assessment section of this report, there are many unmet therapy needs at ASH. In addition, there is no system in place to review the adequacy of the specialty therapies (OT, PT and Speech Therapy). **Compliance:** Non-compliance. **Recommendations:** 1. Develop and implement a system to adequately monitor this

		requirement. 2. See Recommendations for Rehabilitation Therapy Assessments.
d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Findings:** There is no monitoring system in place to ensure compliance with the elements of this requirement. For example, hearing aids that were provided to individuals are not regularly checked to ensure that the individuals who require them actually had them and were using them. Also, they are not being checked to ensure that they are in proper working condition. In addition, there is no formal tracking system in place to ensure that any adaptive equipment is available, in appropriate working condition, and is being cleaned on a regular basis. **Compliance:** Non-compliance. **Recommendation:** Develop and implement a system to monitor the elements of this requirement.
5	**Nutrition Services**	
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed Erin Dengate, Assistant Director of Dietetics. Reviewed charts of 22 individuals (LS, HS, DR, RA, CB, RM, RC, FH, JN, ED, JG, RAU, JB, SB, NC, JD, SW, JT, RL, DL, TT and WT). Reviewed Nutrition Care Monitoring Tool (NCMT). Reviewed Nutrition Care Process (NCP). Reviewed Department of Dietetics Policy and Procedure Manual. Reviewed NST acuity and indicators form. Reviewed list of residents with dysphagia. Reviewed AD Wellness and Recovery Planning. Reviewed AD Treatment Planning. Reviewed Enteral Nutrition Support policy.

		Reviewed Nutritional data provided by ASH. Reviewed AD Therapeutic Diets and Nourishments. Reviewed NCM Enteral Feeding. Reviewed Nursing P & P Care of the Choking Person. Reviewed Nursing P & P Tube Feeding. Reviewed Nursing P & P Development of a Nursing Care Plan. Reviewed Nursing P & P Standards of Care/Practice. Reviewed Nursing P & P Physical Survey.
a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Findings:** ASH reported that policies and procedures, monitoring systems and training programs need to be developed and implemented as required by the EP. Strategies and methodologies by which weight-related and other health concerns are addressed by the WRP teams are not specifically referenced. Triggers related to weight issues have not been implemented. In addition, there is limited participation in and services offered at the Diabetes Clinic. **Compliance:** Non-compliance. **Recommendations:** 1. Revise policies, procedures, protocols, and ADs to address this requirement. 2. Implement a system addressing weight-related triggers. 3. Ensure staff competency regarding weight-related triggers. 4. Develop and implement a monitoring instrument and tracking system addressing the elements of this requirement.
b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the	**Findings:** There is no system in place that ensures that one or more treatment

	dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues. The New Employee Nutrition Class for Level of Care (LOC) staff includes information regarding nutritional issues but does not include competency-based training. In addition, the competence for team members, other than the Registered Dietitian (RD), for dietary and nutritional issues is not addressed. A statewide training tool has not been completed addressing this requirement. Review of item #22 on the NCMT data addressing current RNs' competency-based training in dietary and nutritional issues affecting individuals were 0% compliance. **Compliance:** Non-compliance. **Recommendations:** 1. Develop and implement a monitoring system to ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues. 2. Develop and implement a statewide tool for the training of staff regarding this requirement.
c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and	**Findings:** The current ASH policies and procedures regarding risk of aspiration and dysphagia are inadequate to guide the provision of safe care to this population. The SLP, PT, nurses, and other disciplines have little

	interventions for mealtimes and other activities involving swallowing.	experience and expertise in this particular area. There is no system in place to ensure that a comprehensive, integrated, 24-hour dysphagia care plan is developed and implemented. ASH reported an overall compliance rate of 57% regarding Food/Fluid consistency being addressed when actual/potential aspiration/dysphagia is present. The data were collected from April to September 2006 and the sample varied from month to month. **Compliance:** Partial. **Recommendations:** 1. Ensure that this requirement is met. 2. Revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. 3. Develop and implement 24-hour, individualized dysphagia care plans. 4. Provide competency-based training to staff regarding risk of aspiration/dysphagia. 5. Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. 6. Develop and implement a monitoring system for this requirement.
d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Findings:** ASH has not provided training regarding aspiration and dysphagia, however, there is a plan to begin presentations and competency-based training in the facility.

		Compliance: Partial. **Recommendations:** 1. Ensure staff competency-based training regarding the implementation of this requirement. 2. Develop and implement a monitoring system regarding this requirement.
e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Findings:** The current policies and procedures at ASH do not address all the elements of this requirement. ASH reported 0% compliance regarding Nutrition Services having current policy/procedures on enteral/parenteral nutrition support. From my review, ASH's policies and procedures do not address determining the feasibility of returning to oral intake status from tube feeding. **Compliance:** Partial. **Recommendations:** 1. Revise policies and procedures to reflect the elements of this requirement. 2. Develop and implement a system to monitor this requirement.
6	**Pharmacy Services**	
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that	**Methodology**: Interviewed Kenneth Lundgren, PharmD, Pharmacy Services Manager. Reviewed Pharmacy Policy and Procedure Manual. Reviewed Pharmacist Intervention Reports.

	require:	Reviewed Tool for Chart Documentation Involving Pharmacist Recommendations. Reviewed pharmacy raw data provided by ASH. Reviewed tool used for Quarterly Review for Unit 25 Reviewed ASH Pharmacy Policy and Procedure Manual Reviewed ASH AD #515 Pharmaceutical Services
a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Findings:** There are currently only eight full-time pharmacists at ASH. The department is allotted 14 positions. In addition, there are 15 pharmacy techs. At the current staffing level, ASH is not providing adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. The current ASH pharmacy policies and procedures do not address the elements of this requirement. ASH reported that quarterly Drug Regimen Reviews are not consistently completed due to the current staffing levels for the department. For the months of August, September, and October 2006 only 661 out of 1200 quarterly Drug Regimen Reviews were completed. ASH reported 100% compliance for reviews of new medications that included 3047 new medication orders written from September 5 through September 15 2006. The pharmacy reported 28 interactions with prescribers that included two regarding adverse drug reactions (ADRs), three regarding allergies, two regarding laboratory recommendations, six regarding dosage changes, six regarding drug-drug interactions, and nine regarding other clinical issues. However, there is no monitoring tool or system in place that ensures that all elements of this requirement are adequately addressed. In addition, there is no documentation in the medical records regarding the pharmacists' recommendation or the response from the physician.

		Currently, the pharmacists are inputting their recommendations into an Access database. However, this database does not contain the response from the prescriber. **Compliance:** Partial. **Recommendations:** 1. Revise pharmacy policies and procedures to address this requirement. 2. Develop and implement an electronic system for documentation. 3. Provide IT assistance to pharmacy regarding electronic database and data collection systems. 4. Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.
b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	**Findings:** The current ASH pharmacy policies and procedures do not address this requirement. ASH reported that two recommendations in the pharmacy database indicated "not accepted" by the prescriber. From review by the pharmacist and this reviewer, one record noted that a conversation with the pharmacist had occurred but did not address the clinical issue. The second record did not contain documentation of communication between the pharmacist and the prescriber. ASH reported that most interactions between pharmacy and prescribers are informal and not consistently documented. There is no system in place to ensure that physicians consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.

		Compliance: Non-compliance. **Recommendations:** 1. Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. 2. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. 3. Develop and implement a monitoring system for this requirement.
7	**General Medical Services**	
		Methodology: Interviewed Douglas Shelton, M.D., Chief Physician and Surgeon. Interviewed Madeleine Hernandez, M.D., Staff Physician and Surgeon (Pulmonologist). Interviewed Hani Boutros, M.D., Staff Physician and Surgeon. Interviewed Thomas Cahill, M.D., Staff Physician and Surgeon. Reviewed the charts of six individuals (CDJ, RG, AAC, GEV, RTC and JW). Reviewed Duty Statement of the Medical Staff. Reviewed the Medical Staff Rules and Regulations. Reviewed AD #348 Emergency Services Plan– Life Threatening Emergency (Within Secure Area). Reviewed AD #348.2 Withholding or Withdrawal of Life-Sustaining Services. Reviewed AD #349 Emergency Clinical Laboratory Facilities. Reviewed AD #505 Patient Medical & Psychiatric Examinations. Reviewed AD #517 Medical Officer of the Day & Psychiatric Medical Officer of the Day. Reviewed AD #522 "Outside Consultants/Therapists and Facilities.

		Reviewed AD #523 Clinical Consultation Services. Reviewed AD #525 Pain Management. Reviewed AD #621 Central Medical Services. Reviewed SO #125- Hepatitis C Screening, Diagnosis, Management Guidelines. Reviewed protocol regarding Screening for Diabetes and Initial Management of Pre-Diabetes, Type 1 Diabetes and Symptomatic Type 2 Diabetes. Reviewed Joint National Committee (seventh version) Guideline on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. Reviewed NP #206.2 Referring Patients to Outside Physicians and Medical Facilities. Reviewed Admission Medical Evaluation Treatment Monitor Tool. Reviewed Admission Medical Evaluation Monitoring Summary Data (June to August 2006). Reviewed Ongoing Medical Care Monitoring Tool. Reviewed Ongoing Medical Care Monitoring Summary Data (June to August 2006). Reviewed Monitoring of Medical Appointments and In-House Laboratory Tests Summary Data (April to September 2006). Reviewed Diabetes Care Monitor Tool. Reviewed Hypertension Monitor Tool. Reviewed Management of Hepatitis C Monitor Tool. Reviewed Summary Data of above three monitors (September 2006)..
a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated,	**Findings:** ASH has a medical service that employs 12.5 full-time Physician and Surgeons and one full-time Chief Physician and Surgeon. The physicians provide regular medical coverage of each program as well as medical on-call coverage of the facility at all times. In addition, the facility has a range of on-site specialty clinics, including General/Internal Medicine, Podiatry, Pulmonary Medicine, Optometry, Neurology, Public Health Infectious Diseases, Ophthalmology, Dermatology, Orthopedic Surgery,

	consistent with generally accepted professional standards of care.	General Surgery, Osteoporosis and Urology. These are staffed by ASH physicians or outside physician consultants who are privileged by the facility and are on contract to the hospital. ASH also has contractual arrangements with other outside consultants who provide services in the community in the fields of Cardiology, Oncology/Hematology, Radiation Oncology, Otorhinolaryngology, and Hospitalist Service. Individuals who require a level of care not available on-site are transferred to regional medical centers including Twin Cities Community Hospital, Sierra Vista Regional Medical Center and French Hospital. Individuals requiring advanced level of medical care are transferred on an as needed basis to the University of California at San Francisco (U.C.S.F.), the University of California at Los Angeles (U.C.L.A.) or Stanford University Medical Center. ASH has a medical unit (Unit 1) on-site to provide medically enhanced care for individuals with conditions that cannot be managed on their units but do not require specialized hospital services. Examples include individuals suffering from acute asthma, urinary tract infections, some types of pneumonia and exacerbation of Chronic Obstructive Pulmonary disease (COPD). There is a Medical Officer of the Day (MOD) who provides on-call services for 24 hours from 8:00 am to 8:00 am. All physicians at ASH are licensed and have completed three years of residency training in Internal Medicine, Neurology, Family Practice, General Surgery, or Emergency Medicine. Most of the physicians (10.5 FTE) are board certified in their specialties. AD #348 Emergency Services Plan – Life Threatening Emergency (Within Secure Area) outlines the facility's medical emergency response system. The emergency medical response at ASH is provided primarily

		by nursing staff at the scene of the medical emergency. Contact is made immediately and simultaneously with the ASH Fire Department, the Nurse of the Day (NOD) office and Unit 1 (the Medical Unit). Emergency Medical Technicians (EMTs) working at the ASH Fire Department and a Staff Physician respond as the individual is stabilized and transported to the Urgent Care Room (UCR) at unit 1. At the UCR, the individual is stabilized further or sent to an outside medical center by ambulance. All Physicians and Surgeons at ASH have UCR privileges that require ACLS certification. At this time, ASH has the following three protocols/guidelines that address routine medical care: 1. SO #125- Hepatitis C Screening, Diagnosis, and Management Guidelines; 2. Screening for Diabetes and Initial Management of Pre-Diabetes, Type 1 Diabetes and Symptomatic Type 2 Diabetes; 3. Joint National Committee (seventh version) Guideline on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. At this time, the medical service at ASH has adequate staffing levels and a range of consultation services and contractual arrangements that can meet the needs of the individuals served. This monitor reviewed charts of six individuals that required transfer to a local emergency room and/or hospitalization at an outside facility. The review focused on the timeliness and quality of the medical evaluation of the change in the individual's status and the timeliness and appropriateness of the transfer. The following table outlines the individuals' initials, the reason for the transfer, the date/ and time of the medical evaluation upon the transfer and the date and time of actual transfer.

Individual's Initials	Reason for Transfer	Date/time of Evaluation	Date/time of transfer
CDJ	Acute Myocardial Infarction	9/5/2006 (3:40 am)	9/5/2006 (4:20 am)
AAC	Delirium	1/29/2006 (8:10 pm)	1/29/2006 (9:15 pm)
RTC	R/O Pulmonary Embolism	8/25/06 (2:35 pm)	8/25/06 (2:55 pm)
RG	R/O Pneumonia	6/29/06 (7:45 pm).	6/29/06 (10:08 pm).
GEV	Hyperkalemia	7/1/06 (12:05 pm)	7/1/06 (12:57 pm).
JW	Acute Abdomen	2/13/06 (8:50 pm)	2/13/06 (9:40 pm).

This review indicated that, in general, ASH provides timely and appropriate medical care to its individuals.

ASH does not have a policy and procedure that outlines facility's standards and expectations regarding the following areas:

1. Requirements regarding completeness of all sections of initial assessments;
2. Timeliness and documentation requirements regarding medical attention to changes in the status of individuals;
3. Requirements for preventive health screening of individuals;
4. Proper physician-nurse communications and physician response with timeframes that reflect the urgency of the condition;
5. Emergency medical response system, including drill practice;
6. Communication of needed data to consultants;
7. Timely review and filing of consultation and laboratory reports;
8. Follow-up on consultant's recommendations;

		9. Assessment and documentation of medical risk factors that are relevant to the individual in a manner that facilitates and integrates interdisciplinary interventions needed to reduce the risks; and 10. Parameters for physician participation in the WRP process to improve integration of medical and mental health care. **Compliance:** Partial. **Recommendations:** 1. Continue current practice. 2. Develop and implement policy and procedure to codify facility's standards and expectations regarding the areas outlined above. 3. Ensure that monitoring instruments are aligned with the policy and procedure and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. 4. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports.
b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Findings**: ASH developed and implemented an Admission Medical Evaluation Treatment Monitoring Tool and an Ongoing Medical Care Monitoring Tool. Using these tools, the facility conducted reviews (by peer physicians and surgeons) to assess its compliance with this requirement: The facility reviewed approximately 7-9% of charts of new Admissions each month from June to August 2006 (10 of 129 for June 2006, 10 of 111 for July of 2006, and 10 of 141 for August of 2006). The facility

		also reviewed approximately 20% of Annual Assessments for the same period of time (10 of 26 for June 2006, 10 of 49 for July 2006 and 10 of 51 for August 2006). The following is a summary of the facility's compliance rates and corresponding indicators: 1. Complete Admission History and Physical (H&P) Examination within 24 hours: 97%; 2. All medical needs/conditions are identified in the admission H&P: 93%; 3. Follow up of acute medical problems, including appropriateness, timeliness and follow up of consultations and tests (Admission H&P): 97%; 4. Annual History and Physical (H&P) Examinations are done within the month of the annual anniversary of the last H&P completed: 37%; 5. All medical needs/conditions are identified in the Annual H&P: 90%; and 6. Follow up of medical problems, including appropriateness and timeliness of consultations and tests (Annual H&P): 53%. **Findings:** As above. **Recommendations:** 1. As above. 2. Address and correct factors related to low compliance with the timeliness of the Annual H&P Examinations.
b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical	**Findings**: ASH Reviewed Medical/Surgical Clinic records to determine the number of individuals seen in medical and specialty clinics within the timeframes approved by the Department of Medicine for non-urgent, non-emergent care. The timeframes are adequate. The data showed the following

	status; and the integration of each individual's mental health and medical care;	overall compliance rates for each on-site clinic (April to September 2006): 1. Ophthalmology: 53%; 2. Podiatry: 28%; 3. Optometry: 0%; 4. Foot: 67%; and 5. Medical: 64%. Using the Ongoing Care Monitoring Tool (June to August 2006), the facility found 44% compliance rate with the timeliness of vision care. The Supervising laboratory technician reviewed 100% of laboratory records performed in-house Stat to determine what percentage were reported within 90 minutes of receiving request. The records of April through September 2006 were reviewed. A compliance rate of 93% was found. The facility reviewed Outside Medical Appointment Data Base (April to September) to determine the percentage of appointments completed within the approved eight-week period. A compliance rate of 51% was found. **Recommendations:** As above.
b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Findings**: The current Medical Staff Duty Statement outlines the duties and responsibilities, but does not clearly or adequately address the performance standards and expectations outlined in the EP. **Recommendation:** Ensure that the Duty Statement outlines the performance standards and expectations as above.

b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Findings**: The facility has an AD (#517) that outlines its system of after-hours coverage. The Medical Staff Rules and Regulations (Sections 3.7, 3.8. and 3.9) state the requirements regarding after-hours coverage. There is both a Psychiatric and a Medical Officer of the Day available for after-hours coverage on-site. **Recommendation:** Continue current practice.
b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Findings**: ASH has contracts with regional medical centers that require the timely communication of relevant information upon the return transfer of individuals to the facility. The facility has a process to monitor all return hospitalizations and to notify other centers when needed medical records are not received within required timeframes. The facility has monitored all readmissions of individuals from other medical centers since April 1, 2006 in order to assess compliance with this item. The data indicate that the medical records were received from the outside hospitals within seven days of admission in only ten out of 94 readmissions. **Recommendation:** Develop and implement adequate tracking system.
c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and,	**Findings:** Using the previously mentioned Admission Medical Evaluation Treatment and Ongoing Medical Care Monitoring Tools, the facility assessed its

	whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	compliance with components of this requirement. The indicators used were appropriate to assess these components. The following are the compliance rates and corresponding indicators: 1. Have all focus 6 conditions been addressed with WRP objectives and interventions: 66%; 2. Have WRP services/treatments been provided: 70%; 3. Has there been a change in interventions in response to a change in medical needs: 86%; and 4. Has progress, lack of progress or need for change been noted in the present status section of the WRP: 38%. As mentioned in section C.2., this monitor's reviews indicate that in general, the foci of hospitalization, objectives and interventions are not modified to reflect changes in the physical status of individuals. This deficiency was noted in the services provided to individuals suffering from cognitive disorders, weight changes, substance abuse and seizure disorders. **Compliance:** Partial. **Recommendations:** 1. Continue current monitoring. 2. Address and correct above-mentioned areas of low compliance. 3. Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP.
d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Findings:** ASH does not have a system to monitor, on a comprehensive basis, general outcome indicators to identify trends and patterns in the individual's health status. The hospital is currently setting up a system to collect data on identified medical care triggers.

		The Department of Medicine has approved practice guidelines for the treatment of Diabetes Mellitus and Hypertension. Monitoring tools have been developed to monitor physicians' adherence to these guidelines as well as the DMH-approved SO for the Treatment of Hepatitis C. A review of approximately 10% of all individuals with Diabetes Mellitus (n=192), Hypertension (n=250) and Hepatitis C Virus (n=330) for September of 2006 was performed using monitoring tools that were developed at ASH (Diabetes Monitor Tool, Hypertension Monitor Tool, Management of Hepatitis C Monitor Tool.) Results of the surveys revealed the compliance rates of 74% (Diabetes), 72% (Hypertension) and 88% (Hepatitis C). **Compliance:** Partial. **Recommendations:** 1. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 2. Continue monitoring physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the triggers/key indicators for medical care. 3. Provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. 4. Identify trends and patterns based on clinical and process outcomes. 5. Expedite efforts to automate data systems to facilitate data collection and analysis.

8	**Infection Control**	
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed Gini Dusi, PHN II. Interviewed Carol Whitney, PHN II. Reviewed Infection Control Manual. Reviewed Infection Control Manual Policy and Procedure Review and approval Tracking Form. Reviewed the Infection Control Manual Distribution Tracking tool. Reviewed Infection Reporting Compliance Monitoring data for July-September 2006. Reviewed Identified Pneumonia Cases for April-September 2006. Reviewed Infection Control Data Inventory Monitoring Tool. Reviewed Infection Control Performance Improvement/Risk Assessment Amended Fourth Quarter Report & Annual Review 2005-2006. Reviewed ASH Infection Control Committee Minutes July 27, 2006. Reviewed ASH Public Health Services Infection Report July 2006. Reviewed Environment of Care Inspection Checklist tool. Reviewed Department of Mental Health Public Health Services HIV Infection/AIDS Report tool. Reviewed Medical Waste Management Plan. Reviewed ASH Antibiotic Subcommittee Minutes July 20, 2006. Reviewed Department of Mental Health Public Health Services Patient Tuberculosis Report tool. Reviewed ASH Occupational Health Clinic Tuberculin Skin Test Reaction Investigation tool. Reviewed Department of Mental Health Public Health Services Hepatitis Infection Report tool. Reviewed Antibiotic Usage Review.
a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
a.i	actively collects data regarding infections and	**Findings**:

	communicable diseases;	Although the Infection Control Department at ASH collects data regarding the elements of this requirement, there are no monitoring instruments or systems in place to track data regarding the EP requirements for Infection Control. In addition, ASH reported that there is not a method to assess data over an extended period of time due to a lack of automation. **Recommendations:** 1. Develop and implement a monitoring system for the elements of these requirements. 2. Develop and implement statewide monitoring instruments to monitor the elements for Infection Control. 3. Provide training on the above recommendations to Infection Control staff. 4. Revise policies and procedures to reflect key elements in the requirements for Infection Control. 5. Provide IT support to automate Infection Control data.
a.ii	assesses these data for trends;	**Findings**: There are no monitoring instruments or system in place to track data regarding the EP requirements for Infection Control. **Recommendations:** Same as above.
a.iii	initiates inquiries regarding problematic trends;	As above.
a.iv	identifies necessary corrective action;	As above.
a.v	monitors to ensure that appropriate remedies are achieved; and	As above.
a.vi	integrates this information into each State hospital's	As above.

	quality assurance review.	
9	**Dental Services**	
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed Nolan Nelson, DDS. Interviewed Loren Kirk, DDS. Reviewed dental records and charts of 5 individuals (CR, KK, HP, KM, and MM). Reviewed Memo dated February 14, 2006 regarding "Dental Emergency". Reviewed ASH Dental Care Monitoring Tool and raw data. Reviewed ASH Duty Statements for Chief Dentist and Staff Dentist. Reviewed Dental Refusal/No Show Log. Reviewed Dental Clinic Policy and Procedure Manual. Reviewed Draft of new Dental Record form.
a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Findings:** ASH currently has one staff Dentist, one half-time Dentist (annuitant), one Chief Dentist, and 2.5 dental assistants. The ratio of dentist to patient is 1:833 individuals. In addition, there is no clerical staff in the Dental department to assist with data collection and data entry. Consequently, the staff and Chief Dentists have had to develop and implement a monitoring system, which has taken time away from providing services to the residents at ASH. Currently, ASH reported that the waiting time for a dental appointment is 12 to 14 weeks whereas the waiting time for a community dental appointment was reported as being from 4-6 weeks. The Chief Dentist reported that due to the data collection and monitoring done solely by the staff dentists and without automation, the wait for an appointment could be longer. In addition, ASH has a Dental Hygienist position that they have been unable to fill. A contracted Oral Surgeon comes to ASH once per month. The Chief Dentist also noted that there is no contract for referrals in the areas of Periodontics and Endodontics.

		Currently, there is no system in place to track and monitor individuals diagnosed with Periodontal Disease. In addition, this diagnosis is not included in the Axis III diagnoses listed in the medical records. Consequently, individuals diagnosed with Periodontal Disease are not seen for cleanings and/or treatment as often as needed. Also, the current system for emergency dental services in inadequate. From a review of five individuals' (CR, KK, HP, KM, and MM) dental records and medical charts, this monitor noted significant delays in treatments resulting in prolonged symptoms and loss of teeth. **Compliance:** Partial. **Recommendations:** 1. Evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. 2. Develop and implement a policy to adequately address the management of after-hours dental emergencies. 3. Obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data.
b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
b.i	comprehensive and timely provision of dental services;	**Findings:** The Dental Clinic Policy and Procedure Manual do not adequately address comprehensive provision of dental services. A review of 122 dental records was conducted. ASH reported 90% compliance for new admissions seen within 90 days and 58% compliance for timely annual exams.

		ASH also reported that comprehensive and timely provision of dental services is not up to the community standard of care. However, there is no tool that addresses comprehensive dental services. **Recommendations:** 1. Review and revise policies and procedures as need to address this requirement. 2. Develop and implement a system to ensure that annual dental examinations are completed in a timely manner. 3. Develop and implement a system to monitor and track comprehensive dental services.
b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Findings:** ASH reported 97% compliance for description of treatment provided and 98% compliance for plans of care. There was no data reported regarding findings, however this item was included in the raw data provided by ASH. The dental information kept in the individuals' charts is not consistent with the information kept in the dental department. If charts are not brought to the appointments, information regarding dental services is not accurately reflected. **Recommendations:** 1. Ensure that dental information contained in individuals' records is accurate and up to date. 2. Ensure that staff brings individuals' records to all dental appointments. 3. Report compliance with all elements of this requirement.

b.iii	use of preventive and restorative care whenever possible; and	**Findings:** ASH reported 98% compliance for preventative and restorative care. However, data for both preventative and restorative care were combined. **Recommendations:** 1. Separate data for monitoring and tracking preventative and restorative care. 2. Continue to monitor this requirement.
b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Findings:** ASH reported 100% compliance that extraction cases had x-rays, time-out provisions, and written justifications for the extraction. However, there is no monitoring instrument or system in place to track the elements of this requirement. As noted above, the documentation in the individuals' records was not consistent with documentation in the dental records kept in the dental department. However, justification was present in the dental records presented by the dental department. **Recommendations:** 1. Develop and implement a monitoring instrument and system to track the elements of this requirement. 2. Develop and implement a system to ensure that dental information contained in individuals' records is accurate and up to date.
c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Findings:** There is no monitoring instrument that adequately addresses this requirement. The facility is currently revising the Dental Record to address the elements of this requirement.

		Compliance: Partial. **Recommendations:** Develop and implement a monitoring system that adequately addresses this requirement.
d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	**Findings:** Although ASH has a Dental Refusal/No Show log, this system does not adequately address the elements of this requirement. ASH reported that transportation was not noted as an issue on the Dental Refusal/No Show log. Data demonstrated that refusals and unit staff not informing individuals of appointments were the main reasons for missed appointments. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a system to monitor and track the elements of this requirement. 2. Improve the communication between the unit staff and residents regarding dental appointments.
e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Findings:** ASH reported that the current procedure for refusals for dental services included sending a memo to the units when an individual refuses dental services. However, there has been no follow-up by the WR

		teams. In addition, there is no system in place to monitor and track actions taken by the teams. **Compliance:** Partial. **Recommendations:** 1. Develop and implement a system to monitor and track interventions and outcomes for dental refusals. 2. Develop and implement a facility-wide system to facilitate communication with dental and the Wellness and Recovery teams regarding individualized strategies to address refusals of dental appointments and treatments.
10	**Special Education**	
	Each State hospital shall provide the school-age and other residents, as required by law, who qualify for special education ("students"), individualized educational programs that are reasonably calculated to enable these students to receive educational benefits, as defined by applicable law.	
a	Each State hospital shall develop and implement uniform systems for assessing students' individual educational needs and monitoring their individual progress.	
b	Each State hospital shall ensure that all Individual Education Plans ("IEPs") are developed and implemented consistent with the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq. (2002) ("IDEA").	
c	Each State hospital shall ensure that teachers providing instruction to students at each State hospital have completed competency-based training regarding teaching and academic instruction, behavioral interventions, monitoring of academic and behavioral progress and incident management and reporting.	

d	Each State hospital shall ensure that students receive instruction and behavioral supports appropriate to their learning abilities and needs, consistent with generally accepted professional standards of care.	
e	Each State hospital shall provide appropriate literacy instruction, consistent with generally accepted professional standards of care, for students who show deficits in one or more common areas of reading (e.g., decoding or comprehending).	
f	Each State hospital shall on admission and as statutorily required thereafter, assess each student's capacity to participate, with appropriate supports and services, in an integrated, non-institutional, education environment, and provide access to an integrated education environment for those students who can participate in one with appropriate supports and services.	
g	Each State hospital shall ensure that all students receive their education in the least restrictive setting pursuant to the requirements of the IDEA, consistent with their legal and clinical status.	

G	Documentation		
		Summary of Progress: 1. The DMH WRP manual includes criteria for the proper documentation of the main components of the new WRP model. 2. ASH has implemented the required formats for the WRP model in most of its programs. 3. ASH has adequate requirements regarding the timeliness and completeness of psychiatric progress reviews and inter-unit transfer assessments. 4. ASH has completed a self-assessment process and identified a variety of patterns that require performance improvement in the documentation of assessments, reassessments and WRP. 5. ASH has implemented the formats for the admission and integrated nursing assessments on four units. 6. Many of the discipline-specific assessments are completed in a timely manner.	
	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Findings:** The previously mentioned findings of deficiencies in the documentation of admission and integrated assessments (D.1. through D.7) and the main components of integrated therapeutic and rehabilitation services (C.2.b through C.2.i) and specific therapeutic and rehabilitation services (F.1 through F.7) indicate that the documentation of these systems is generally inadequate. **Compliance:** Partial. **Recommendations:** 1. Revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP. 2. Develop and implement a system to monitor and track the quality of documentation.	

		3. Ensure staff competency in the implementation of documentation requirements.

H	Restraints, Seclusion, and PRN and Stat Medication	
		Summary of Progress: 1. A majority of ASH staff have adopted the Wellness and Recovery Model to guide provision of services to individuals with serious mental illness. 2. ASH has begun to identify and implement needed revisions in its policies and procedures regarding seclusion, restraints, PRN and Stat medications to ensure compliance with the EP. 3. Monitoring and tracking systems are currently being put in place to ensure that proper procedures are being implemented. 4. ASH is sincerely committed to decreasing the use of seclusion/restraints and PRN and Stat medications. 5. ASH is beginning to thoughtfully and candidly identify some of its deficits through the process of self-assessment. 6. Many of the ASH staff members are committed to making the needed changes to enhance the lives of the individuals residing at ASH. 7. The disciplines at ASH are critically reviewing their systems in order to make the necessary changes.
	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** Interviewed David Fennell, M.D., Medical Director Interviewed Colleen Love, D.N.Sc, Director of the Clinical Safety Project. Interviewed Donna Nelson, Assistant Clinical Administrator. Interviewed Joe Cornach, Statistical Methods Analyst for the Clinical Safety Project. Reviewed Seclusion/Restraint Audit form. Reviewed ASH Section H Monitoring Tool 2. Reviewed Restraint and Seclusion data. Reviewed 24 Hour Medication Audit form. Reviewed charts of 12 individuals (JG, RA, JB, SB, NC, JD, SW, JT, RL, DL, TT and WT).

1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Findings:** Currently, ASH's policy permits prone containment/transport as an exception to the general prohibition of its use in an emergency that renders other positioning options impossible. This is in conflict with the elements of this requirement. From my discussion with Dr. Colleen Love and Dr. David Fennell, it was described that in an emergency situation during a takedown followed by a brief period of stabilizing the individual, the person may be in a prone position during this time. However, once secured, it was reported that the individual was then placed in a supine position and monitored throughout the process. This situation does not constitute containment or transportation. In addition, the other ASH policies need revision to be in compliance with this requirement. ASH reported that no persons are ever restrained in a prone position. **Compliance:** Partial. **Recommendations:** 1. Review and revise policies and procedures that currently allow the use of prone containment. 2. Prohibit the use of prone restraints, prone containment, and prone transportation immediately.
2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered	**Findings**: There is no monitoring instrument or tracking system in place to monitor the elements of this requirement. ASH provided data using

	in a clinically justifiable manner or exhausted;	two different methodologies and had significantly different results for each method. From my review of the charts of seven individuals who experienced the use of restraints, I found that four contained documentation of imminent danger and none included documentation that a hierarchy of less restrictive measures was tried. **Recommendations:** 1. Develop and implement a monitoring instrument and a tracking system to adequately address the elements of this requirement. 2. Ensure that policies and procedures include implementing seclusion and restraints only after a hierarchy of less restrictive measures have been considered in a clinically justifiable manner or exhausted with supporting documentation to be logged in the medical record.
b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Findings**: ASH does not have an adequate tracking system for this requirement. ASH is currently looking at hours of treatment provided and quality of documentation, and institutional or operational needs in making determinations regarding this requirement. **Recommendation:** Develop and implement a system to monitor the key elements of this requirement.
c	are not used as part of a behavioral intervention; and	**Findings**: ASH does not have a monitoring and tracking system in place for this requirement. ASH reported that from the review conducted from the two different

		methods, both found that seclusion and/or restraints were not used as part of a behavioral intervention. From my review of WRPs for four individuals, I did not find indications that seclusion and/or restraints were used as part of a behavioral intervention. **Recommendation:** Develop and implement a system to monitor and track this requirement.
d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Findings**: ASH does not have a monitoring and tracking system in place for the elements of this requirement. ASH reviewed documentation of seclusion and/or restraint and found that these interventions continued in some cases when the individual was most likely no longer dangerous. Some nursing assessments were inadequate in terms of documenting continuous dangerousness and mental status. Release criteria were rarely documented. **Recommendation:** Develop and implement a system to monitor and track this requirement.
3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Findings:** ASH reported 100% compliance for continuous monitoring. ASH's data did not address the requirement regarding Psychiatric Technician Assistants (PTAs) having completed competency-based training for the restraint/seclusion class. In addition, the data provided for physician or licensed clinical professional assessing within one hour did not address this element. The data from ASH does not address all the elements of this requirement. There is no monitoring instrument or tracking system in place for this requirement.

		Compliance: Partial. **Recommendation:** Develop and implement a system to monitor and ensure compliance with all elements of this requirement.
4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Findings:** There is no monitoring instrument or tracking system in place for this requirement. **Compliance:** Non-compliance. **Recommendation:** Develop and implement a system to monitor and ensure compliance with all elements of this requirement.
5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Findings:** ASH reported that there is a tracking system for monitoring of triggers on all programs. ASH reviewed 44 incidents to see if the information from the debriefing form was incorporated into the WRP. There were 22 debriefing forms found and none were noted to update the WRP. There were no data provided regarding the revision of policies and procedures regarding this requirement. **Compliance:** Non-compliance.

		Recommendations: 1. Revise appropriate policies and procedures to ensure compliance with this requirement. 2. Develop and implement a monitoring system to ensure that there is documentation of a review within three business days of WRPs for any individuals placed in seclusion or restraints more than three times in any four-week period and modification of therapeutic and rehabilitation service plans, as appropriate.
6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Findings:** ASH reports having monitoring and tracking systems for the use of PRN medications. However, the data provided by the facility did not address the elements of this requirement. From my review, I noted that CB was receiving a PRN of diphenhy-dramine and/or lorazepam and/or temazepam for insomnia/agitation every night from October 9 to November 17, 2006 without review of the underlying cause. **Recommendations:** 1. Develop and implement policy/procedure to outline facility's standards regarding PRN/Stat medication use consistent with the requirements of the EP. 2. Develop and implement triggers for review and follow-through by medical and nursing leadership. 3. Develop and implement a monitoring and tracking system addressing the elements of this requirement.

b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	The facility reports 27% compliance.
c	PRN medications are appropriately time limited.	The facility reports 0% compliance.
d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Findings**: ASH reported 93% compliance. However, the documentation consisted of either "effective" or "not effective" and did not have an associated IDN in the chart. This data included both PRN and Stat medications. **Recommendations:** Develop and implement a monitoring instrument to accurately monitor this requirement.
e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Findings:** Same as in D.1.f. **Recommendations:** Same as in D.1.
7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Findings:** ASH reported 93% compliance for Prevention and Management of Assaultive Behavior (PMAB) competency-based training and 96% compliance in medication certification. ASH does not have an adequate monitoring system in place for this requirement. In addition, there has been no competency-based training for each of the applicable policies. **Compliance:** Partial. **Recommendations:** 1. Develop and implement competency-based training on this

		requirement. 2. Develop and implement a monitoring instrument and tracking system to accurately monitor this requirement.
8	Each State hospital shall:	**Compliance:** Non-compliance.
a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Findings**: ASH does not have a monitoring instrument or tracking system in place for the key elements of this requirement. The facility has reported that side rail use has been for the prevention of falls and not as a type of restraint. Clarification and review of this issue is needed to determine the parameters of side rail use. **Recommendations:** 1. Develop and implement policy/procedure to outline facility's standards regarding side rail use consistent with the requirements of the EP. 2. Develop and implement a monitoring instrument to accurately monitor this requirement.
b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Findings**: ASH does not have a monitoring system in place addressing the elements of this requirement. There has been no system developed and implemented in accordance with the EP. **Recommendations:** 1. Develop and implement a system to ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that

		warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate. 2. Develop and implement an instrument to accurately monitor this requirement.

I	Protection From Harm	
	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. ASH has policies that require the reporting of incidents and forms for this purpose. All incidents are reported on an SIR (Special Incident Report). These forms are logged in electronically and the database contains some key variables. Presently this system is not used to produce report on a regular basis. Thus, there is no tracking of patterns and trends and no identification of high-risk situations. 2. ASH has two tracks for the investigation of incidents: criminal done by the DPS (Department of Police Services) and breach of duty investigations completed by the Special Investigators. Neither investigation adequately addresses programmatic and administrative issues. 3. Incident notification and data and the collection and analysis of trigger data is fragmented among several different committees/persons/departments. This results in data of questionable accuracy and, in the case of incidents, no analysis. 4. The hospital has three layers of government in which individuals in treatment participate. This allows them to bring concerns and requests to the attention of the administration. 5. The hospital has gathered some trigger data. Triggers regarding the use of restraint and seclusion, 1:1, the use of emergency medications and similar data are monitored daily and a response from the unit is required. 6. The hospital has an Environment of Care (EOC) team that inspects units on a rotating basis. These inspections include attention to the personal care needs of individuals.
1	**Incident Management**	
	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally	**Methodology:** Interviewed L. Holt, Chief of Police. Interviewed D. Landrum, Lieutenant, Criminal Investigator.

	accepted professional standards of care.	Interviewed B. Swift, Senior Special Investigator. Interviewed L. Wilkes, Hospital Administrator. Interviewed C. Love, Director, Clinical Safety Project. Interviewed J. Cormack, Clinical Safety Project. Interviewed C. Mathiesen, Director-Evaluation and Outcome Services. Interviewed C. Moxness, Acting Training Officer. Interviewed D. Nelson, Assistant to the Clinical Administrator. Interviewed D. Orlando, Hospital Administrator Resident. Interviewed L. Persons, HR Director. Interviewed E. Andres, Personnel Officer. Reviewed 25 Department of Police Service (DPS) and Special Investigator (SI) investigations. Reviewed the list of employees who have not completed Abuse and Neglect training. Reviewed mandatory reporting acknowledgement in personnel files of 12 employees.
a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Findings**: AD 906 states that staff who within the scope of their employment observe or have knowledge of an incident that reasonably appears to be abuse, or reasonably suspects abuse might have occurred, must report it. A full page in the booklet given to staff upon hiring, "Basic Principles of Performance Improvement and Patient Safety", states the hospital's zero tolerance for abuse and neglect. AD 103 requires any staff member witnessing or suspecting an incident of patient abuse, physical, verbal or psychological to immediately report it to his/her immediate supervisor.

		There is some evidence that staff is not clear about their obligation to complete an SIR (Special Incident Report) whenever an incident occurs. In conversation, one senior staff member said that she did not believe it would be necessary for a staff person to complete an SIR if an individual complained of staff abuse that happened a week earlier and for which there were no witnesses. Additionally, my investigation indicates there is a need to clarify that both an SIR and SOC #341 (mandated reporter form for dependent adult abuse) must be completed without delay whenever there is an allegation of abuse/neglect, even when the hospital police have taken a crime report. In an incident involving WS and JS, the crime report was dated May 17, 2006, while the SOC #341 report was dated May 24, 2006. In almost one-third of the SIR and 341 forms I reviewed, data was either missing or in error. As examples, reporters did not sign or did not date forms [2 of 3 forms reporting incident on September 5, 2006 involving JC, FI and RB were not dated]; injury boxes were not checked on the 341 form [TL and JW incident of February 10, 2006, RS and AJ incident of February 9, 2006 and RB and JB incident of July 29, 2006]; the date was not filled in on 341 form [WW and JH incident] and no incident type, date or description was completed on 341 form for JJ and JC incident. **Recommendations:** 1. Clarify in the soon-to-be-initiated annual Abuse/Neglect Awareness training that all allegations must be reported unless there is substantive evidence that the event could not have occurred. The absence of witnesses does not negate the obligation to report. 2. Clarify which reporting forms are used for which purpose and identify those situations when staff must complete both reporting forms.

		3. Revise the curriculum for Dependent Adult Abuse training (as per the outline) to include the need to complete a SIR as well as a SOC #341 form. 4. Carefully review SIR and SOC #341 forms for accuracy, completeness and timeliness at the unit level.
a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Findings**: The state is revising the definitions of sexual incident on the SIR form that adds space for the notification to the Department of Children and Family Services of child abuse allegations. ASH AD #809 effective July 18, 2006 needs review. It defines as one type of Headquarter Reportable Incident alleged abuse by hospital employees, service providers *and any other persons.* This would seem to include individual-to-individual abuse (battery/assault, etc.). I do not believe this is the intent of the policy. **Recommendations:** 1. Continue work on the definitions related to sexual incidents. 2. Clarify which abuse allegations should be reported to Head quarters and revise the policy as necessary.
a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Findings**: In none of the cases reviewed was there documentation that the alleged perpetrator (staff member) was removed from contact with the individual. In an interview, the Police Lieutenant stated that the determination whether to reassign a staff member to a non-individual contact position or to remove the staff member from the facility entirely is made on a case-by-case basis. The facility is revising AD # 906 to include this information, as the issue of removal is not addressed presently in any Administrative Directive. I saw no evidence in the investigations reviewed that individuals who

		sustained an injury were not evaluated and afforded treatment as necessary. **Recommendations:** 1. Include in the revision to AD #906 the specific circumstances under which a staff member will be removed from the alleged victim. Removal must continue until the investigation is closed. 2. Include in all abuse investigations the fact that removal was considered and the reason why it was or was not implemented.
a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Findings**: Presently employees receive a total of two hours of training on abuse/neglect Awareness and Prevention and Individuals' Rights—a one-hour training module and 15-20 minute trainings within other modules, e.g. individuals' rights. The training curriculum outline includes indicators of abuse. The competency test at the conclusion of the one-hour abuse/neglect training is well done and actually evaluates the employee's understanding of the material. ASH plans to initiate annual refresher abuse/neglect training within the next few months as soon as the Executive Team approves the proposal. The facility reports that 90.18% of all staff has received the abuse/neglect training. I confirmed this figure by requesting a report of all staff who have not completed abuse/neglect training. This report listed 202 staff members (total staff number approximately 2100). The job classifications with the highest percentage of staff not attending were physicians/surgeons and psychiatrists—as a group, 25% had not attended. **Recommendations:** 1. Secure approval for and implement plans to begin annual A/N

		refresher training. 2. Train those staff members who have not attended A/N training, including physicians.
a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Findings**: All employees of ASH are mandatory reporters. I reviewed the personnel records of 12 staff members whose names I encountered while reviewing documents and matched the date they signed the mandatory reporting acknowledgement form with the date of hire. This sample included recent hires and long-term employees. Eleven of the 12 signed the form either on the date of hire or earlier when they had been cleared for hire, but were not yet on the payroll. In one case a staff member hired in 1980 did not sign the form until 1986. HR staff researched further, and we concluded that 1986 was the earliest staff signed the form. ASH is presently developing a database that with other information will track the date of hire and the date the acknowledgment of mandatory reporter form was signed. **Recommendations:** 1. Continue work on the database. 2. During investigations, ask individuals to whom they made the first report of the allegation.
a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Findings**: Individuals are supposed to sign an acknowledgement that they have received notification of their rights upon admission and annually thereafter. All three individuals reviewed on admission unit 13 had signed the acknowledgement. Results for a review of annual acknowledgement on Unit 28 revealed that of the three records reviewed, JP and LW had last signed in March and April 2005 respectively and OC signed in November 2004.

		On admission, all individuals are given a Program 1 New Patient Information Packet. ASH is revising this packet to project a recovery attitude and use recovery language. All three units where I asked, Units 2, 4 and 28, had a supply of forms for making a complaint to the Patients Rights Advocate. The Office of Patients' Rights provides each individual a "Patients' Rights Informational Handout" that lists rights applicable to all individual and rights for individuals committed under specific legal statutes and how to make a complaint to the Office. ASH has representation on a state-wide workgroup to ensure that conservators receive information related to relevant hospital policies. **Recommendations:** 1. At the WRP meeting nearest to the anniversary of the individual's admission date, ask the individual to again review and sign the rights statement. 2. Continue participation in the workgroup dealing with informing conservators. 3. Proceed with plans to revise the New Patient Information Packet.
a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Findings**: There was a posting advising individuals how to report violations of their rights in each unit I visited. **Recommendation:** Continue current practice.
a.viii	procedures for referring, as appropriate, allegations of	**Findings**:

	abuse or neglect to law enforcement; and	All incidents that may involve a crime, including allegations of staff-to-individual abuse and individual-to-individual battery and assaults are investigated by DPS. Upon completion of the investigation, appropriate cases are referred to the District Attorney's office. A log of DPS cases is sent regularly to the California Department of Justice. Notification is made to the FBI of staff-to-individual battery and assault. Intake of SIR and SOC 341 reporting forms is fragmented. For example, the July 26, 2006 allegation of staff abuse made by DB was logged in at the SI office on August 3, 2006. It does not appear on the SIR database report for July, August and September. This fragmentation means the facility does not have an accurate count of incidents. It can also cause a delay in reports being forwarded to DPS in a timely manner. When a staff member has completed a 341, it is forwarded to the Special Investigator who maintains a hand-written log. If a SIR has not been completed at the same time, the incident is not logged in on the SIR database. The Chief of Police reviews the SIR database daily, but does not see the 341s. Therefore, in those instances where staff does not complete a SIR and the police are not called to the scene, a delay in reporting to law enforcement may occur. (See b.iv.1) **Recommendations:** 1. Identify one department where all SIR and 341 reports are logged in, matched, reviewed for accuracy and completeness and from which they are forwarded to the appropriate investigative body. Standards Compliance is most often this "first stop" and is then responsible for the analysis of incident data and the production of monthly incident data reports. 2. Equip that department to complete the tasks necessary for the management of incidents.

a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Findings**: There is presently no document that states that persons who report allegations of abuse and neglect will not be subject to retaliation. ASH is revising AD 906 and AD 602 to include language to cover this issue. The revisions were forwarded to the Policy Management Committee in October 2006. The committee meets monthly. **Recommendations:** 1. Include in AD 906 the expectation that staff will report any threats or acts of retaliation to management immediately. 2. Direct staff in training sessions to report any threats or acts of retaliation to management.
b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Findings**: All investigations of death, allegations of abuse, neglect, serious injury and any other actions that may constitute a crime are investigated by DPS or the Office of the Special Investigator in compliance with ASH AD #807 Senior Special Investigator and AD #801 Department of Police Services. These offices are independent and do not report to any service program or department. All officers have had investigation training and training in working with persons with mental illness. **Recommendation:** Continue current practice.
b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on	**Findings**: See b.i.

	the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Recommendation:** Continue current practice
b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Findings**: In several of the investigations reviewed, photographs were properly labeled and included in the investigation file. In the 5/8/06 incident where SD was assaulted by another individual, the weapon (soap in a sock) was "booked as evidence." **Recommendation:** Continue current practice.
b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Findings**: In theory, allegations of abuse/neglect are to be investigated by the Special Investigator for employees' misconduct, as distinct from the DPS investigation of criminal activity. These investigations should identify issues and make recommendations related to referrals of staff for discipline and training and programmatic and systemic changes to improve care and treatment. Presently, these investigations often fall short of that mission. All incidents of individual-to-individual assaults, battery (including fights with no clear aggressor and those where an aggressor can be identified) and sexual abuse are investigated and reviewed (approved) by DPS officers. Without a review that looks beyond a determination of criminality, program and systemic issues may be undetected and uncorrected. **Recommendations:** 1. Clarify and document the hospital's expectations of the parameters of a Special Investigation of allegations of A/N.

		2. Identify a body of staff to serve as an Incident Review Committee to review Special Investigations for competency and to ensure that programmatic and systemic issues are identified and recommendations for corrective actions made. 3. Identify a procedure whereby individual-to-individual physical and sexual assault allegations can be reviewed for program and systemic issues.
b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Findings**: In many instances, DPS responds immediately to calls from the units and completes a crime report. In some cases, however, the investigations do not commence in a timely manner. On September 5, 2006 three individuals were engaging in sexual activity. Three 341 forms were completed. Two were not dated; one was dated September 15, 2006. DPS got the report on October 5, 2006 and began an investigation on October 12, 2006. DPS closed the investigation on October 13, 2006. The Senior Investigator memo to the file, dated October 17, 2006, states that the allegation is a criminal matter and is being referred to BPS. Similarly, on June 17, 2006 KP alleged that a staff member struck him. The case was logged in at the SI office on July 6, 2006. The crime report was dated July 5, 2006. The unfounded determination was received back at the SI's office and he acknowledged that he would take no further action on August 15, 2006. **Recommendations:** Same as in a.viii.
b.iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Findings**: DPS documents indicate that 44 misdemeanor cases and 12 felonies that were reported prior to October (two of the felonies were ready to go the DA) are completed before submission to the DA's office and remain open during the time of the DA's review or prosecution. The log kept by the Special Investigator does not indicate when a case has

		been closed. In addition, this log is incomplete as two of the six SI investigations I reviewed (January 8, 2006 allegation of verbal abuse and July 31, 2006 allegation of improper restraint hold) did not appear on the log. Also, the log does not differentiate in the column labeled "Employee Name" whether the identified person is the reporter of the incident or the alleged perpetrator when the entry relates to a staff-to-individual abuse allegation. ASH reported that three individuals died in 2006. The death of LB (July 16, 2006) was expected, as he was grievously ill. The investigation did not raise any questions. However, the SI did not complete the Resident Death Report form. The identifying information was filled in, but questions 18-28 and the disposition were not completed. The form was not signed and dated. The deaths of two other individuals occurred on October 27, 2006 and November 3, 2006. Investigations had been initiated on both deaths but not completed awaiting post-mortem examination results. [It should be noted that the description of LB's death revealed that staff were attentive and compassionate—playing his favorite music and stroking his head.] **Recommendations:** 1. Identify the source of the problems in the SI office. Some of the problems may be due to insufficient resources. 2. Provide increased supervision of the SI office, at least until the problems are resolved. 3. Research the source of the delay in completing investigations in the DPS. This may also relate to a resource issue.
b.iv.3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set	**Findings**: All investigations resulted in a written report. No investigations reviewed identified corrective actions. Some investigations failed to state a determination of whether the case was substantiated. I saw no documentation that investigators were considering the issue of staff

	forth explicitly and separately:	neglect, which in most of the cases would be a failure to protect. **Recommendation:** Adopt a standard face sheet for SI investigations that includes the identifying information, persons interviewed, documents reviewed and the outcome (substantiated or not substantiated. Include relevant dates, such as date case received, assigned, closed.
b.iv.3(i)	each allegation of wrongdoing investigated;	**Findings**: The investigations reviewed all contained a statement of the allegation of wrongdoing under investigation. However, in the 1/8/06 allegation involving WD, the investigation focused on the exchange of touch (not sexual) between the staff member and the individual, and the allegation of verbal abuse was overlooked and not investigated. **Recommendation:** Review all allegations to ensure that those which, in part or in whole, do not involve possible criminal activity are investigated by the Special Investigator.
b.iv.3(ii)	the name(s) of all witnesses;	**Findings**: The names of all witnesses interviewed were identified in the investigation reports reviewed. However, in some relevant cases there was no attempt to interview additional persons who may have seen or heard the incident. For example, in the 7/31/06 allegation involving a neck hold placed on NC, the investigation strongly suggests that individuals in the dining room saw the take-down and neck hold. None of these individuals was interviewed. **Recommendation:** Do not overlook other individuals and staff, beyond those identified on the incident report, who may have heard or seen an incident. Document attempts to find these persons and interview them.

b.iv.3(iii)	the name(s) of all alleged victims and perpetrators;	**Findings**: All investigations reviewed identified the names of alleged victims and perpetrators. **Recommendation:** Continue current practice.
b.iv.3(iv)	the names of all persons interviewed during the investigation;	**Findings**: All investigations reviewed included the names of all persons interviewed. **Recommendation:** Continue current practice.
b.iv.3(v)	a summary of each interview;	**Findings**: Each investigation reviewed contained a summary of each interview; however in most cases, the interview consisted of letting individuals and staff members tell their version of what happened. There was little indication that questions were asked to clarify conflicting information, and in no investigation reviewed were any second interviews done after additional information had been gathered. **Recommendations:** 1. Ask follow-up questions when conflicting information is presented. Indicate in the report when information was obtained in response to a question. 2. Question and document where staff was when the incident occurred.
b.iv.3(vi)	a list of all documents reviewed during the investigation;	**Findings**: T The investigations reviewed did not evidence a review of any documents beyond the incident reporting forms, which include the

		narrative description of the incident that remains in the individual's record. The absence of a review of the individual's WRP is indicative of the lack of review of programmatic issues and formulation of recommendations. **Recommendation:** Invest in the reviewing body [see b.iv] the responsibility to review WRPs and other relevant documents that would form the foundation for programmatic corrective actions.
b.iv.3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Findings**: One investigation completed by the SI did not meet current practice standards in its failure to consider all sources of information. An individual's mother alleged that her son had been verbally abused by unit staff. She identified herself, her son, and the unit. (The SOC 341 does not contain a date of the allegation.) A memo dated August 4, 2006 states that the Unit Supervisor interviewed all unit staff and "was unable to locate anyone who had witnessed any verbal abuse of [BY]. No further work on this allegation was done by the SI (no further conversation with the mother, no interview of the alleged victim and no interview of any other individuals on the unit). There is no indication in the investigation file if, or how, the findings were communicated to the complainant. The criminal investigations completed by DPS do not look at prior bad acts. There is no such prohibition in the cases reviewed by the SI. **Recommendations:** 1. Develop the capacity for the SI, unit supervisors and relevant administrators to review the incident history of any individual or staff member. 2. Look for similarities in type of incidents, circumstances (e.g. language or gestures used) as well as the number of incidents.

b.iv.3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Findings**: Several investigations did not specifically state the findings and did not clearly identify whether the case was substantiated. For example, in the June 12, 2006 incident where VM alleged a staff member verbally abused him, a staff witness confirmed the abuse. On June 16, 2006 the investigation was closed, but no disposition was documented. On July 16, 2006 a memo from the SI stated that this matter was criminal and *no further action would be taken by his office*. The memo was clearly in error. Further investigation on my part revealed that the case had been forwarded to Human Resources and an adverse action against the employee is being prepared. I also learned, however, that all substantiated allegations of verbal abuse are not forwarded to Human Resources. **Recommendations:** 1. Complete all investigations by specifying a disposition and any referrals made. 2. Write a clear and concise statement of findings that supports the disposition. 3. Develop guides that specify the conditions under which a referral must be made to Human Resources.
a.iv.3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Findings**: The SI investigations reviewed did not include a summary statement providing a rationale for the disposition. As indicated in b.iv.3(v), second interviews were not conducted in the investigations reviewed and additional witnesses were not sought. **Recommendation:** Improve the documentation of attempts to reconcile conflicting evidence.

b.iv.4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Findings**: All investigations completed by the DPS are reviewed for thoroughness and accuracy by supervisors in the Department. The investigations completed by the Special Investigator are reviewed by the Chief of Police. These review processes do not address programmatic or administrative issues. In this respect, the investigations are incomplete and the reviews are inadequate. **Recommendations:** 1. Develop a review process for DPS and Special Investigator investigations that identifies programmatic and administrative issues and makes recommendations for corrective actions. 2. Invest in the single department managing incidents the responsibility to ensure that recommended corrective actions have been effectively implemented in a timely manner and report the results of this monitoring to the unit/programs involved and to the hospital administration.
c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Findings:** The Special Investigator investigations I reviewed did not contain evidence that necessary programmatic and disciplinary actions had been taken. Section b.iv.4 discusses the absence of programmatic finding and recommendations. In the incident involving the neck hold placed on MP (July 31, 2006) where three staff members confirmed the use of the unauthorized hold, the SI wrote that he believed the staff member "did not intentionally attempt to harm [MP] when he restrained him." [It is not clear how he made this determination.] The SI and the Acting Program Director decided the issue would be handled by program management and no further action would be taken by the SI office. My further review at the unit level indicated that a Letter of Instruction dated September 14, 2006 was placed in the staff member's unit file instructing him to attend PMAB training on September 18, 2006. While acknowledging that corrective measures

		were taken, this investigation, nonetheless, illustrates the hospital's lack of standardized responses to staff misconduct to ensure that similar offenses are dealt with even-handedly. It further illustrates the difficulty in "closing the loop" to ensure that effective corrective measures are implemented. **Compliance:** Partial. **Recommendations:** 1. See b.iv.4. 2. See b.iv.3(viii) 3. Keep a log of Adverse Actions. 4. Invest the single department managing incidents with the responsibility to track programmatic and administrative recommendations and the effective implementation of corrective actions, as well as the implementation of recommendations for staff training.
d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Non-compliance.
d.i	type of incident;	**Findings**: ASH is not presently using incident data to identify high-risk individuals and situations and to protect individuals from harm. In February 2007 DPS will be getting a Records Management System that will be capable of producing reports on incidents investigated by the hospital police on multiple variables. **Recommendations:** 1. Identify those elements that the SIR database can report on and begin producing a monthly report that identifies basic

		incident information, such as type of incident, date, location, conclusion (substantiation or not), individual involved. 2. Later display this information in a meaningful form that will facilitate the identification of patterns and trends. 3. Review the capability of the DPS Record Management System to identify how it can be useful to the entire hospital, without compromising legal requirements for confidentiality, etc.
d.ii	staff involved and staff present;	**Findings**: The investigation reports reviewed identified the staff members involved in the incident. The investigation reports did not identify all staff present. The Special Incident Report log for July, August and September does not identify staff member(s) involved. **Recommendation:** Ensure that the database can provide information on the staff persons involved. These names will not be part of the monthly report, but must be reviewed by the designated staff to identify staff members who are frequently named, so that further investigation will be initiated.
d.iii	individuals directly and indirectly involved;	**Findings**: A review of the Special Incident Reports log (July to September, 2006) reveals that in 35 of the 40 incidents in September 2006 involving individual-to-individual aggression, the identity (by hospital number) of each of the individuals involved was documented. Some of this information was missing in five incidents. **Recommendations:** 1. Same as d.ii. 2. Ensure that the SI database regularly identify all parties in those investigations where at least two individuals are involved.

d.iv	location of incident;	**Findings**: The Special Incident Reports log (September 9, 2006) includes information about the location of the incident. **Recommendation:** Analyze the data using the location variable.
d.v	date and time of incident;	**Findings**: The incident database can identify the date of the incident, but not the time. **Recommendations:** Same as d.i.
d.vi	cause(s) of incident; and	**Findings**: The incident database cannot identify the cause of an incident when it is different from the type. **Recommendation:** Review the definitions of incident types to include whenever possible causal information, so that persons reading the report will be able to identify the cause.
d.vii	outcome of investigation.	**Findings**: The outcome of all investigations was not clearly documented. See illustration in b.iv.3(viii). The Special Incident Reports log (July to September, 2006) contains no information on the outcome of the investigation. **Recommendations:** 1. Same as in b.iv.3(viii) 2. Add outcome information to the Special Incident Report log. This will give the facility the information necessary to calculate

		its substantiation rate and will facilitate tracking of personnel-related corrective measures while the full incident management system is being developed.
e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	**Findings:** All potential staff members are fingerprinted and their criminal history is investigated prior to hiring. This information is kept by the DPS. According to the Human Resource Director, there are generally two conditions under which volunteers assist at the hospital: in the Match Two program and when speakers are invited in (e.g. to speak at an AA or NA meeting). When an outside speaker is in the hospital, he/she is continuously supervised by an ASH staff person. In the Match Two program (a small, less than 15 volunteers, mentoring program) volunteers meet with an individual once a month. These volunteers receive an orientation that includes the abuse/neglect Awareness video. **Compliance:** Substantial. **Recommendation:** Continue current practice.
2	**Performance Improvement**	
	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management	**Methodology:** Interviewed D. Orlando, Hospital Administrator Resident. Interviewed C. Love, Director, Clinical Safety Project. Interviewed J. Cormack, Clinical Safety Officer. Interviewed C. Mathiesen, Director, Evaluation and Outcome Services (EOS). Interviewed D. Nelson, Assistant Clinical Administrator.

	process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	Interviewed S. Heber, Acting Standards Compliance Coordinator. Interviewed B. Dougherty, Standards Compliance Office. Reviewed trigger information for specific individuals. Reviewed aggregate trigger information.
a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Findings**: The hospital has collected data on 28 trigger items. For the vast majority of these triggers, data has been collected each month for June 2006 through September 2006. Those responsible for collecting, inputting and analyzing the data agree that there is a reliability problem. There were numerous and sometimes significant discrepancies between the SC data and the data from the Clinical Safety Project. Both of these departments collect data on Triggers one, two, three, six, seven, 12, 14, 15 and 17, with data collected on 23 separate items for four months, equaling 92 data items. The data from the two departments did not agree on 28 of the 92 items (25%). **Recommendations:** 1. Eliminate the fragmentation in the collection of trigger data and consolidate responsibility in one department. Most commonly this would be the Standards Compliance Office. 2. Perform a reliability check on the data and identify the source of the problem, in the meantime.
a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A;	**Findings**: It is appropriate to modify the trigger dealing with abuse and neglect

	and	to eliminate the requirement for an injury. A trigger is needed that identifies persons who are repeat victims of individual-to-individual aggression. **Recommendation:** Continue current practice.
a.iii	identification of systemic trends and patterns of high risk situations.	**Findings**: Since data for the third month only became available during our tour, it would be premature for the hospital to be identifying patterns and trends of high-risk situations. **Recommendation:** Continue to refine data collection methods to improve accuracy, so that trending and pattern data, when produced, will be useful.
b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Findings**: The hospital has created a hierarchy of responses to the non-medical triggers. Level 1, for example, requires a mini-team review. Level 2 (3 different triggers in 30 days) requires a review by the nurse coordinator and a senior psychiatrist. Level 2 reviews have been delayed waiting for an allocation of senior psychiatrists. Level 3 reviews (6 different triggers in 60 days) are conducted by the Behavioral Consultation Committee. **Recommendation:** Continue work on the new tracking system that will allow the tracking of specific treatment recommendations.

b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Findings**: See b.ii. **Recommendations:** Same as in a.iii and b.i.
b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Findings**: See b.i. **Recommendations:** 1. Continue to refine the trigger tracking system. 2. Ensure that the new trigger tracking system will provide an individual's trigger history when requested.
b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Findings**: As noted above, more reliable and useful feedback loops were under development and were to be rolled out immediately following our visit. **Recommendation:** Continue making improvements to the trigger tracking system.
b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Findings**: See b.iv. **Recommendation:** Proceed with the full development of the trigger identification, response and oversight system.
c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Findings:** The hospital's ability to assess compliance with its service goals is hindered by the questionable accuracy of much of the data. This must be addressed before any performance measurement is attempted.

		Compliance: Non-compliance. **Recommendations:** 1. Identify the source(s) of the problems in collecting accurate data. It may be that staff are not operating with the same set of definitions/instructions or are not heeding them. 2. Provide discipline/program-specific training to staff as needed. 3. Address the fragmentation of data collection and analysis that is compounding the problems.
3	**Environmental Conditions**	
	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Had conversations and toured units with L. Euler, Chief of Plant Operations and S. Everett, Health and Safety Officer Interviewed C. Constien, Coordinator of Nursing Services Reviewed inspection records Toured nine units.
a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Findings:** The hospital completed a baseline environmental review in June 2005. This reviewed, among many other issues, 24 environmental issues related to potential suicide hazards. Compliance on ten of the 24 issues was rated 95% or better. The hospital has been replacing bed springs with solid supports. The October 2006 environmental review completed on Units 22, 23 and the Day Treatment Program related to potential suicide hazards indicates 100% compliance in all but three of the issue areas. The three issues concerned access to electrical outlet to the typewriter, the presence of contraband and window bar coverings. During my review of nine units, I did not see any suicide hazards. Residential units are inspected semi-annually by the Environmental Inspection Team. Units and programs are not given

		advance notice of the inspections. Programs are expected to return a Plan of Correction for cited deficiencies. **Compliance:** Partial **Recommendation:** Continue current practice.
b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Findings:** The temperature of the units I visited was comfortable. Water temperature in the bathroom sinks was appropriately warm. Air and water temperature is centrally controlled. Water temperature is monitored centrally on an hourly basis. **Compliance:** Substantial compliance. **Recommendation:** Continue current practice.
c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Findings:** The Nursing Services Coordinator acknowledged that presently there is no system for collecting accurate data on individuals with incontinence. Information is presently being collected from Health Services supervisors who are reviewing such data as lists of individuals who use briefs. The lists are compiled by Central Supply. The facility plans to write a bowel/bladder nursing procedure manual. Work on this has not yet begun. **Compliance:** Partial.

		Recommendations: 1. Begin the work of writing the bowel/bladder nursing procedure. 2. Ensure that all persons on the list, albeit the list may not be complete, have a plan addressing incontinence. Include bathroom schedules and other measures as appropriate that help preserve the individual's dignity.
d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Findings:** The hospital prohibits sexual activity between individuals. This is codified in AD #504. When individuals are found engaging in or admit to having engaged in sexual contact they are counseled on the prohibition and on STDs. The hospital does not make condoms available to individuals. **Compliance:** Partial. **Recommendation:** Clarify the confusing language in AD #504. One part of the AD states that all sexual activity in the hospital is illegal. Following that part, the AD specifically prohibits acts of sodomy and oral copulation for dually committed PC 1370/1026 CDC and PC 2684. Through an interview, I learned that the intent of this provision is to clarify that for these individuals such acts must be reported to an outside entity.
e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Findings:** The hospital does not use untrained staff in capacities, e.g. as Mall instructors, where they would be responding to incidents. If non-nursing and other untrained staff should begin to provide Mall instruction, the hospital will need to develop a training curriculum for them.

		Compliance: Partial. **Recommendations:** Develop a training curriculum for the situations described, as the need arises.

J	First Amendment and Due Process	
		Summary of Progress: 1. The hospital has three levels of government in which individuals are active: Unit government, Program Meetings and the Hospital Advisory Council. The HAC meets monthly and drafts proposals for consideration and response by the administration. 2. The hospital conducted a random survey of 30 individuals asking questions related to, but not limited to, safety, environment of care, treatment by staff, input into WRP, and the use of restraint and/or seclusion.
	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology**: Attended the Hospital Advisory Council meeting. Interviewed seven individuals on the units. Reviewed documentation of the work of the Hospital Advisory Council.
		Findings: Eighty two% of the respondents to the random survey reported they felt safe, but only 59% responded that they had been taught what constitutes abuse and neglect. The information related to restraint and seclusion is not convincing. Only two of the individuals reported that they had been placed in restraints or seclusion, yet three individuals responded they were assisted to calm down first and three reported they were not helped. Three persons indicated that they were released when they were calm. In my interviews with seven individuals I asked them to rate on a scale of 1-10 how safe they felt. [1=not safe at all, 10=very safe and secure] The response range was from 4-9. Two individuals alleged being choked by staff members in an incident. There was no documentation that the facility investigated these allegations. This monitor was not in a position to substantiate the allegations or determine if the facility had failed to report and/or respond to these allegations. The monitor

		reported the allegations, without names of the individuals involved, to the Director of the Clinical Safety Project. **Compliance:** Partial. **Recommendations:** 1. Enlarge the sample of individuals who are asked to respond to the survey and continue to survey on a regular basis. 2. Specifically questions individuals about the use of choke holds and incidents when they were choked. Document the findings of this review. 3. Implement corrective measures indicated by the results of the surveys.
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